S. HRG. 103–881

HEALTH CARE BENEFITS PACKAGE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MARCH 3, 1994

Printed for the use of the Committee on Finance

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HEALTH CARE BENEFITS PACKAGE

THURSDAY, MARCH 3, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Rockefeller, Packwood, Dole, Danforth, Chafee, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H–12, February 28, 1994]

FINANCE COMMITTEE SETS HEARING ON HEALTH BENEFITS PACKAGE

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on the benefits packages of proposed health care reform bills.

The hearing will begin at *10:00 a.m. on Thursday, March 3, 1994* in room SD–215 of the Dirksen Senate Office Building.

"The Committee will examine the scope of benefits provided under various reform proposals, including the President's," Senator Moynihan said in announcing the hearing. "We will also examine what benefits are typically offered under current insurance plans, and how proposed benefit packages are imagined to work with other aspects of health care reform."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished guests and our yet more distinguished witnesses. May I apologize for this slight delay. The weather is inclement. But we are here and in sufficiently good time to welcome first Dr. Judith Feder, who is now the Principal Deputy Assistant Secretary. How many Deputy Assistant Secretaries are there?

Dr. FEDER. There may be many. I would be happy to provide it for the record. [Laughter.]

No. No, Bob Dole would just get it and make a chart of it. [Laughter.]

The CHAIRMAN. No, we do not want that.

And with Dr. Feder is Dr. Herdman, who is the Director of the Office of Technology Assessment here in our government. We welcome you, Doctor, most specifically.

Senator Packwood, you are ever ready with an opening comment.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. I am, Mr. Chairman. And for every hearing I keep thinking this is the most vital hearing; and today is one of the most vital hearings. What is going to be in the benefit package is probably of greater concern to more people than any other single thing we might do. How you are going to reimburse hospitals is of interest to hospitals. And how you are going to regulate carriers is of interest to carriers.

What the benefits are going to be is of interest to every person in the country. I support universal coverage and I am prepared to support a mandate to do so. But we cannot provide every benefit to every person that everybody wants at taxpayer expense. We cannot. So there has to be some limit somehow.

And yet every group that is in any way tertiarily, tangentially connected to health care is convinced they are the linchpin of the program and without them there is no program. So we have all been visited, and visited, and visited by different groups that are convinced they must be in the program.

So as you write this, you think to yourself, what should be the benefits that you cover? Should the patient have to pay part of it or how much of it? Should there be a limit on visits to the hospital? Is there an ultimate limit beyond which we do not pay, even on catastrophic? Those are all questions that we have to determine.

I might say, I am rather proud of my State of Oregon. A little later on we will have a witness from the State of Oregon, because we have faced this problem. We established a Health Commission a number of years ago and we said we are going to try to provide increased benefits for those on Medicaid.

We would raise the limit to the poverty level of who we covered. We tried to rank the medical procedures that existed and to value them and to say we will have a list, and we will pay for the ones at the top of the list, and we will not pay for the ones at the bottom of the list. And some of the ones we will not pay for are the ones for which treatment does no good.

We no longer pay to treat the common cold. We cannot figure out how to treat it, so there is no point on spending money on treating it.

But we are going to have to do the same thing at the national level that Oregon has done, unless we just say it is open ended—we pay for everything for everybody. Any bill that is ever submitted by anyone we pay. And we are not going to do that.

Then we have to say, which bills are we going to pay and for which procedures. Oregon has faced that. The national will have to face that. I am delighted that we have witnesses today that are going to tell us, Mr. Chairman, exactly how we should face that.

The CHAIRMAN. Well, once again Oregon is first. It is a curious thing we have learned from our hearings; and it also happens to be true, that this is a big country and people manage their affairs in different ways in different places.

And another place they manage then in different ways is the great State of Montana. Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. We are watching the Oregon plan very carefully. We are also very proud, I might say, of setting up our own health care authority somewhat modeled after another State, and that is Vermont.

The State of Vermont is very similar to Montana since we have rural population. We are asking our State to study two plans—single payer and multi-pay, similar to the Vermont charge. And, frankly, I must say that we in our State are quite excited about that, as we are, frankly, about as most people across the country in national health anyway.

We need to reform. I must just say, Mr. Chairman, we are watching Oregon and I found two of the most doctors I talked to in Montana like the Oregon plan. The reason they like it, I think, because it makes some decisions for them. They do not have to decide, you know, whether to cover this procedure or that. The State of Oregon has pretty much——

The CHAIRMAN. Montana sends cases to Oregon.

Senator BAUCUS. Only if they are in that top tier above the cutoff. [Laughter.]

Actually, we do not. We have very good medical centers in our State in Billings and also in Great Falls.

The CHAIRMAN. Wyoming does not, I take it.

Senator BAUCUS. Well, we get a lot of Wyoming patients actually. But the big, big, big cases actually go to the coast—either to Seattle or they go back to Rochester in Minnesota.

The CHAIRMAN. In Minnesota.

Senator BAUCUS. That is correct.

The CHAIRMAN. One of the problems we have and it would be helpful if we heard from our witnesses on this, and it is something Senator Danforth would be sensitive to—the idea of public decisions about matters that are this intimate and this close to the very elements of existence. The public is not very good at this.

I mean, I think to this day doctors are taught to write prescriptions in a script that only pharmacists can understand. Is that not right? It has to be. Dr. Herdman?

Dr. HERDMAN. They use Latin and abbreviations which make it hard for the lay public.

The CHAIRMAN. Yes, to keep it mystified and to keep it so that the public will not have access to what is basically a mystery, for which there are rites and for which there are ordinations and about which the less you know probably the better for you.

This is a normal pattern. I can remember in my distant youth in the State of New York in the 1950's, kidney dialysis had appeared. The question began to arise, how many patients would be served by kidney dialysis, the alternative of which is death.

There were budget examiners—very able, professional people—trained at the Maxwell School of Public Administration, who had never been trained in deciding how many people should live and how many people should die. It was just not within their range of reference. It was something only such as Senator Danforth could make a decision about and by ancient agreement.

It was understood he could. Would you try to expand on this, my friend?

OPENING STATEMENT OF HON. JOHN C. DANFORTH, A U.S. SENATOR FROM MISSOURI

Senator DANFORTH. Mr. Chairman, I think that Senator Packwood really put it very well. I really do believe that this is the most important issue and the most difficult issue, politically and ethically, with respect to reforming our health care system. The question is, how do we say no.

It is a political issue, as Senator Packwood pointed out, because there are all of these groups representing various aspects of providing health care. They want to know if the service that they provide is going to be covered. But it is also a question that is on the minds and will increasingly be on the minds of individual members of the public.

I was in a meeting outside of St. Louis on Sunday and one person in the audience put up her hand and she said I have such and such a condition and the cost is $100,000 a year. Is it going to be covered? I was able to duck that question because I said some Board is going to decide that, not me.

If politicians decide it, the answer is yes, everything is going to be covered. But according to everybody's plan, if there is going to be a defined benefit package, somebody is going to say eventually yes or no.

The only reason for a list of defined benefits is that there are some things that are not on the list. There is no such thing as a list of everything that is on it. So you have a list for the purpose of excluding some things.

Are we who are ultimately responsible, the politicians, even though we buck that decision to a Board, are we going to be able to say no to anything? And if so, to what? Are we going to go into this legislation just saying, well, we have no idea, we have no criteria, it is all up to some Board? Or are we going to at least consider it in advance? I take it that the reason for this hearing is to consider it in advance. It is very, very important.

I would only add this, that unless health care is the be all and end all of our country, then it is essential that we say no to something. Unless the costs are going to be truly totally out of control, always, it is essential that we say no to something. How do we make those decisions? What is the basis for making them? It is a very interesting subject.

The CHAIRMAN. But would you take my point that they used to be made in Latin.

Senator DANFORTH. But it should be made in Latin?

The CHAIRMAN. They used to be. They used to be.

Senator DANFORTH. It used to be made in Latin?

The CHAIRMAN. Yes.

Senator DANFORTH. Well, maybe in that case Latin was the precursor of a Board.

The CHAIRMAN. No. Would you take my point it is possible that that citizen of Missouri who asked you that question will learn from your having successfully avoided the answer and next time

said, Senator, will you appoint a member of the Board who will designate this condition.

Senator DANFORTH. I can see that as being a very crucial question in future campaigns. Not for me, of course, perhaps for you. [Laughter.]

The CHAIRMAN. Senator Rockefeller, help.

Senator ROCKEFELLER. Mr. Chairman, I did not have a statement, but this is such an intriguing Socratic dialogue that I feel intellectually impoverished if I do not subtract from it. [Laughter.]

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. I think the point needs to be made, and I hope it will be made this morning, that the Clinton package is not a Cadillac plan. I agree with what Senator Packwood said, and that is, we cannot do everything for everybody. I agree with Senator Danforth in that we will not. We cannot. I think political people have the will to say no on things like this. We actually do it fairly often.

The only difference between this and what you would probably call a standard Blue Cross-Blue Shield plan as opposed to a high option plan is two things, two things alone, two add-ons.

One is called preventive health care which, of course, is wonderful. It adds about 3 percent to the total cost of the package. That is all. Preventive health care is basically what health care has to be about and it is not in a lot of present insurance policies.

The other is mental health. Otherwise, there are no differences between a standard Blue Cross-Blue Shield plan and this one. So I think those who say it is first dollar coverage, which it is not, or they say it is too rich, ought to be required to defend why they think it is too rich and what is in it that they think is too rich.

Was that acceptable, Mr. Chairman?

The CHAIRMAN. That is not acceptable. That is a perfect introduction to Dr. Feder.

Good morning, Dr. Feder.

STATEMENT OF JUDITH FEDER, PH.D., PRINCIPAL DEPUTY ASSISTANT SECRETARY, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. FEDER. Good morning, Mr. Chairman, members of the committee. It is a pleasure to be here and we certainly share your view, the importance of addressing the benefit question. I will direct my remarks to the benefits in just a moment.

But I think that in light of the discussion you have been having, it is very important to note that benefits are only a part of the issues that have to be addressed in achieving efficient delivery of quality care and that the President's plan addresses this issue in a number of ways.

And just to define it broadly, we are looking at changing the incentives in our health care delivery system to both encourage and enable doctors and other providers to focus on and truly manage the efficient delivery of quality of care. So I just wanted to establish that as a context.

And then to go on, what I want to direct my remarks to this morning is explaining why it is that we believe it is important to specify a comprehensive package of benefits in the legislation and then talk about the specifics of the President's program.

In terms of specifying the comprehensive package, the importance thereof, we believe that it is necessary both for reasons of fiscal responsibility and for ensuring Americans' security of coverage as we move forward in health reform.

Basically, it is not possible to estimate or assure adequate financing for coverage, unless we specify the benefit package that we are covering and we are expecting employers, individuals and the government to contribute to as we move forward in guaranteeing health care coverage.

And as to what is in the package, security, the concern that people have about what they will be getting under reform and how it compares to what it is today, we feel it is essential to specify that package in order to give people the confidence as to what they can get.

We also feel that it is necessary to specify a standard and comprehensive package to avoid the perpetuation, even in a transition, of uncompensated care, two-tier medicine and the cost shifting that exists today, to encourage the most efficient use of necessary or appropriate services, both to treat health care problems and to prevent health care problems, so that we have a broad range of services that can be provided; and to facilitate the comparison and choice of insurance plans in a world in which people are able to choose but need to be able to compare apples and apples in the insurance marketplace, so as to have a standard and comprehensive package.

The President's Health Security Act achieves these objectives. I would like to tell you how. First, we do provide a comprehensive set of benefits and guarantee that package for all Americans and it is a package that is comparable to the protection most Americans have today.

As Senator Rockefeller observed, it is not a Cadillac package. It is at about the median of packages that are common today, as has been noted by the Congressional Budget Office.

It is also important to note that the comprehensive benefits package provides cost sharing options for consumers that are standardized in order to ensure simplicity in comparing plans. These options serve to protect consumers from the devastating costs of catastrophic illnesses through limits on out-of-pocket spending. But they also promote personal responsibility and the appropriate use of health services through co-payments and co-insurance requirements.

Of course, low-income individuals are eligible for assistance with these requirements, so that they are guaranteed protections consistent with their ability to pay.

Now let me turn to some of the specific benefits that we have included in the President's plan. First, prevention, the cornerstone of the Health Security Act. The comprehensive benefits package includes a wide array of preventive services not covered by today's insurance plans.

The plan offers periodic clinician visits for children, adolescents and adults, which provide an opportunity for prevention, monitoring and counseling appropriate to people's age, gender and developmental circumstances.

Our first investment in healthy children is good prenatal care for mothers. To remove any financial barriers to these critical services, the Health Security Act provides for complete prenatal care, along with other specified preventive services without any cost sharing.

For the first time under the President's Health Security Plan, all persons with mental and substance abuse disorders, and their families, will have access to specialized services without life time limits. The proposal would give health plans the flexibility to provide appropriate type, mix and level of services for each individual and would make a dramatic step in eliminating the historic discrimination against those who were suffering from mental illness and substance abuse.

Every American, including those who are so poor that they currently qualify for health care coverage under Medicaid, would be guaranteed the Federal benefit package. But we recognize that children who are covered under Medicaid currently receive some broader benefits that would go beyond this package.

Consequently, the President's plan includes a new program, a capped Federal program, to provide for these extra services for poor children. People with disabilities also need protection. And as we look at this benefit package, comprehensive as it is, we see that it has some limitations when it comes to services for chronic conditions, not so much medical services as the kinds of personal support people with disabilities require.

Again, Mr. Chairman, we believe that security requires that we address these problems and it is for that reason that the President's plan includes a long-term care program directed at the biggest gap in the system, services at home and in the community where people with disabilities want to stay.

Mr. Chairman, the Health Security Act was designed to guarantee comprehensive coverage and security at affordable costs to eliminate the problems millions of Americans are facing with exclusions for pre-existing conditions, life time limits and inadequate services in the insurance plan they have, let alone the problems for those without any insurance coverage at all.

We believe we have established a balance between security and affordability and we look forward to working with you to achieve that goal.

The CHAIRMAN. Thank you, Dr. Feder.

[The prepared statement of Dr. Feder appears in the appendix.]

The CHAIRMAN. Senator Dole, you have always stayed through the whole hearing, so I am sure you would want to hear Dr. Herdman first.

Senator DOLE. Yes.

The CHAIRMAN. Dr. Herdman, good morning, sir.

STATEMENT OF ROGER C. HERDMAN, M.D., DIRECTOR, OFFICE OF TECHNOLOGY ASSESSMENT, WASHINGTON, DC

Dr. HERDMAN. Good morning, Mr. Chairman, Ranking Minority Member, Senator Packwood.

The CHAIRMAN. That does not look like a Bob Dole chart at all. It looks very, very straightforward. Wait until he gets through it. [Laughter.]

Dr. HERDMAN. This is a nonpartisan chart, Mr. Chairman.

The benefit package can be viewed as a centerpiece of health care reform. The American public will to a large extent judge the success of reform based on the services they get from the health care system relative to the prices that they pay. The package will determine what people get, what people pay, the major implications for success of cost control, the nature of relationships to other parts of reform. It will need repeated attention and it cannot be done by science alone.

This morning I would like to focus on the relationship of the benefit package to other parts of reform and to say a few words about the size and scope and how those will be determined.

The chart that you alluded to, Mr. Chairman, at the top has the benefits, what patients get, and the filters through which those benefits in general must pass. We try to ensure that specific patients get needed care. The point is that you need to pay attention to the filters as much as to the benefit package itself.

The benefit package, as it says, is a list of covered services, like obstetric services and preventive services, of items like prescription drugs, eyeglasses and prostheses of providers like nurse practitioners and chiropractors and physicians, of settings like in-patient hospital or school-based health clinics, and a list of conditions like technology dependent children or severe mental retardation.

Legislation varies in how it specifies these benefits, either precisely or broadly or in calling for others to help to define them. It usually includes language about medical necessity and some language about excluded benefits.

So what people will get then depends on what is in the package and how it is modified by the filters. Also, I have some other influences over there, that is availability of services because there are some services that are not available in rural areas and individual preferences. Even though preventive services may be available, compliance is not very good on some of those things. Those are amenable to public health programs but are not going to be covered today.

In general, the overall specificity of a benefit package, as Dr. Feder has mentioned, does have an impact on what people get because it has an impact on what the local level can do in terms of providing or not providing the service.

More specifically, we assume that the filters are there because one believes waste can be squeezed out. The issues are complex. But in essence, although there is probably a lot of waste, people estimate in the area of 20 percent or so, there may be under utilization as well as over utilization. The Agency for Health Care Policy and Research guidelines have stressed, in fact, underutilization.

The CHAIRMAN. Underutilization in facilities you mean?

Dr. HERDMAN. Underutilization of services. So if you are going to filter out services, Mr. Chairman, for example——

The CHAIRMAN. Services are?

Dr. HERDMAN. What people get.

The CHAIRMAN. Yes, but you do not want to put them into sort of an ice box full of services—you can reach in and get one out. There are more available if there is more demand. I can see underutilization of hospital beds. I understand that.

Dr. HERDMAN. Well, my point in talking about using finance as a way of filtering how the benefit package ultimately ends up in terms of what people are getting is that it is a tool for filtering out unneeded services. When you use financing as that tool—that assumes there are unneeded services wasted and you have to keep in mind that some of what are referred to as the inappropriate service may be underutilization as well as overutilization.

Anyway, let me continue. It is uncertain how effective these filters can be. I am just going to mention a few, some of which have been raised already. Cost sharing places the burden of filtering on potential patients and drives out appropriate as well as inappropriate care, although it saves money. It diminishes care and may have an impact on health outcomes.

Expenditure caps place the burden of filtering on payers, plans, and providers, and there is no evidence that unnecessary care selectively decreases. Some proposals are more stringent than any historically known to OTA. With a comprehensive package, pressures to exceed caps may raise questions of the possible effectiveness of the caps and, therefore, the effect of this control on cost.

To sum up, financing provisions may affect costs, but will also affect what benefits are delivered. The evidence that they will ensure that only needed parts of the package are delivered is poor. Utilization controls in managed care place the burden of filtering on providers and plans. Managed care plans may or may not decrease utilization appropriately.

There is certainly evidence that managed care plans lower the use of some services, and some evidence that they may lower premiums, but no evidence of inappropriate care reduction and no evidence of differences in health outcomes. Although managed care plans are a feature of great interest, they certainly require careful structuring.

My written testimony mentions, as Senator Packwood has alluded to earlier, influences which will be brought to bear on the committee by States, employers, insurers, providers, consumers and the like, all of whom have their own particular axes to grind. I wish you well in sorting out these conflicting positions from all of these individuals and groups.

I am not going to dwell anymore on that because I want to get on to my comment that there is no completely scientific way to design a benefit package. We do not find that there is cost effectiveness or effectiveness data for many or most interventions.

Senator Packwood alluded to the Oregon experiment which did rank conditions, but it did so with a final analysis based on subjective value-based judgments, rather than on scientific information. That was the way it had to be done.

We have looked specifically at two items, which we can report on. One is clinical preventive services. Here I wanted to emphasize that many clinical preventive services are an excellent buy and something that should be supported, a good investment. But many

have not been evaluated for effectiveness and many more have not been evaluated for cost effectiveness.

Clinical preventive services rarely demonstrate cost savings. You need to consider special populations, the frequency in which they are applied and other factors such as total aggregate cost, otherwise coverage can run costs into the tens of billions of dollars per individual preventive technology. They need to be looked at with care, even though they are good buys.

The same sort of thing can be said for mental health, where there is little cost effectiveness information. There is a variable set of conditions in treatments. But some treatments have been shown to be effective and some coverage seems justified.

So let me conclude, because I see my red light is on, we believe are ready for reform which would have at least two objectives slowing the growth rate of expenditures and providing access for all. The benefit package will be the centerpiece of all this. The questions I have touched on, and many more, will need to be addressed if the objectives are to be approached.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Dr. Herdman. We thank you in particular for a very careful paper with a rich appendix of citations.

[The prepared statement of Dr. Herdman appears in the appendix.]

Dr. HERDMAN. I wish I had been able to summarize it a little more fluently for you, Mr. Chairman.

The CHAIRMAN. Well, now, please, we have that document. Let me in a confessional mode speak to our two witnesses and to the committee about my one experience, in which I can say I have had some real involvement with government medicine and government involvement with medicine, because you have spoken of it, Dr. Feder, in terms of for the first time all persons with mental and substance abuse disorders in their families will have access to specialized services. You mentioned the cost benefit studies on mental illness.

I will tell this tale, to tell a story, as they say in social science these days. I was in the room in the spring of 1955 in the State Governor's office in Albany when Jack Bingham, a former member of the House, then Secretary to the Governor, brought in Paul Hoke, the new Commissioner of Mental Hygiene, with Paul Appleby, the Director of the Budget. He had been Truman's Deputy Director.

Hoke said to Herman that a fellow named Nathan Kline at Rockland State Hospital had developed a treatment for schizophrenia. It was he who had synthesized the active ingredient in the root rauwolfia, which had been used in Vedic medicine for millennia. Hoke, who had been head of the Psychiatric Research Institute said he thought it was time we should use it system wide. Herman asked how much it would cost—$5 million. Appleby said he had the money. Herman said I am an investment banker. We kept having to tell him to stop saying that he was an investment banker. But he said, "I believe in this investment," and we made it.

The scene shifts; I come to Washington. The Congress has commissioned a joint commission on mental illness. It also has learned

of what we now call tranquilizers, and it proposes deinstitutionalization.

The last public bill signing ceremony of John F. Kennedy was on October 23, 1963 when he signed the Community Mental Health Center Construction Act of 1963, and he gave me a pen. We were going to build 2,000 of these centers by the year 1980, 1 per 100,000, and continue on that pattern. We were going to empty out our institutions and treat people locally.

We emptied out our institutions. They now have about 12 percent of the population they had on the day the President signed that bill. But we did not build the community mental health centers. We overestimated the capacity of these medications and 31 years later we have a problem with homelessness.

I know it is this kind of problem because they have it in Seattle, not just the south Bronx. And government has redefined this problem as lack of affordable housing and has proven incapable of retrieving the origins of the problem and analyzing it in an acceptable form and doing anything about it.

All they have done is take people out of not very handsome facilities, but at least Rockland State Hospital was warm at this time of year, and the streets of the south Bronx are frozen. The people who have been in Rockland State are now sleeping on the streets and we are saying it is because we have not got housing.

The government has been incapable of doing anything about this. And you suggest we are going to have specialized services for them.

Dr. FEDER. Mr. Chairman, your recollections raise a number of issues. But the one that I would focus on in what you said is the problem that exists as long as we have some services covered and not others. There is a tremendous incentive. We are buck passing in this system across providers, across level of governments, across funding sources.

So that essentially when the State——

The CHAIRMAN. I know that.

Dr. FEDER. Yes.

The CHAIRMAN. I have been around 40 years.

Dr. FEDER. I was only drawing on what—I meant to draw on what you said and to note that essentially that one of our objectives is, by providing more comprehensive coverage——

The CHAIRMAN. We built 400 of the 2,000 and then we forgot we had done that. Why do you not just start getting on to mental health and getting those poor wretched people off the streets?

Dr. FEDER. Well, in the specifics, we would reinvest essentially in community facilities.

The CHAIRMAN. Are you going to put people back in Rockland State Hospital?

Dr. FEDER. No. We would invest. What we want is to provide an appropriate array of services, which are both in the——

The CHAIRMAN. What is that?

Dr. FEDER. It would mean having services in community health centers. We have had a lot of years of neglect. And those facilities need to be developed; services need to be developed and they need to be covered. Your concerns are well taken.

The CHAIRMAN. That is what we said in 1963.

Dr. Herdman, in two seconds.

Dr. HERDMAN. Just very quickly, I think what I take away from that is that if you are going to make some dramatic changes based on a new availability of treatment for schizophrenia—and I certainly agree the one you mentioned does not work very well—and you add a benefit, you would be well advised to know how much it might cost, and you would be well advised before you get into that, to look carefully at the effect of this end cost effectiveness if you can.

The CHAIRMAN. Thank you very much. Just a cautionary tale.

Senator Packwood?

Senator PACKWOOD. I am intrigued, Dr. Herdman, with your statement about preventive services. You say just be careful when you talk about average illnesses and cost and whether or not it is cost effective or not as opposed to Dr. Feder indicating that preventive services will be high on the list.

I know everyone thinks preventive services are cost effective. There is a presumption—it is the stitch in time theory. I suppose many are. I would assume if you can inoculate every child, that is probably cost effective. But could you comment a little more or expand a little more on preventive services and where you would be wary about getting into what we might regard as preventive services because the cost benefit is just marginal or perhaps negative?

Dr. HERDMAN. Sure. Let me say that there are really two terms I think we have to be careful of. One is the term cost saving. I think there if you know that that is the case, you feel pretty easy about adding a benefit. Cost effective——

Senator PACKWOOD. Would that mean if you inoculate babies it is probably cost effective?

Dr. HERDMAN. Cost saving would be and the ones that are usually mentioned are three. That is, immunizations in children, prenatal care, and neonatal screening for hypothyroidism and PKU done at the same time.

Those are I think pretty clearly cost saving—you could argue there may be others. But those are ones that are most cited. That is, the amount of money you spend to do it is less than the amount of money that you save in care that would have occurred had you not made the identifications early on.

Cost effectiveness is a relative term. OTA has done cost effective analyses on a number of occasions for Congress.

For the Medicare program, particular benefits such as pneumococcal vaccine, mammography, cervical cancer screening and the like were considered for addition. Cost effective means that there was a calculus arrived at where, generally speaking, it was said that it was so many dollars saved—excuse me, it costs so many dollars to save a year of life—of the population.

For example, in mammography if you screened every 2 years for women in the Medicare population it would cost you about $35,000 for every year of life that you saved in that population by intervention. The other key fact to know was that to actually carry out that screening cost you—I have forgotten the figure, but it was, let us say, a billion or so a year.

So there were other interventions where the cost per year of life was much higher and there were some like cervical cancer screening, under certain conditions—this is where the frequency came

in—for example, if you did it every 4 years as opposed to every year, it would cost something like $10,000 per year. That sounds like a pretty good buy.

But it still costs you money that you would not otherwise have spent unless you were making that intervention. So we would come before the Congress and we would say, that is a wonderful buy. But let us just keep in mind you are going to spend the money.

Now there were other preventive interventions which we looked into, such as cholesterol screening and, of course, the treatment when you found high cholesterol. Under certain conditions the evidence was not very good. And if you took the whole population, and if you screened everybody for cholesterol and you provided dietary and drug treatment for those with modest elevations of cholesterol, you could end up spending tens of billions of dollars every year on that one intervention.

The same is true for—as I recall, for colorectal cancer. So what I am saying is, you need to know how much it is going to cost you in the aggregate, how effective in total. In other words you could have an intervention that was pretty cheap but did not make much difference or you could have one that cost more, but maybe would an enormous difference.

It is a complicated situation. We have done reports which could explain that to you. I also recommend to you something that was not done by OTA, which is out just recently from the Millbank Memorial Fund by Louise Russell called "Educated Guesses," talking about three interventions—prostate, cholesterol, and cervical cancer.

You know about that book, Mr. Chairman. It is an interesting discussion of some of the things I have just said. I do not want to at all leave the impression that we do not support preventive interventions, not at all. I just want to say that you should keep your eyes open and——

Senator PACKWOOD. Well, you are also saying, if there is a limited amount of money, there might be some things the money is better spent on than some preventive services.

Dr. HERDMAN. That would be a decision that the Congress could reach, of course.

Senator PACKWOOD. Dr. Feder, could you comment?

Dr. FEDER. Yes, I would want to, Senator Packwood, because I believe that we have recognized these concerns in developing the package. There has been a lot of discussion of some of the services that we did or did not identify for coverage as preventive services, which means with no cost sharing.

We identified a subset for no cost sharing. And we did, indeed, draw on scientific evidence in that regard and there are some services that some would like to have in for which there is no such evidence. And, consequently, we did not include them in that list.

We left it also, we felt that that is something that should by no means be fixed, that what we know about what works and what is effective and what is not is something that we learn about over time. So that is a reason that we have a Board that looks at the evidence and can make changes in that list over time.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Packwood.

I would just like to say, we have really exhibited extraordinary capacities for learning with our experience in discharging mental patients from institutions. It is an absolute catastrophe, a tribute to ignorance and all that is wrong; and it would never have happened if we had not set out to improve things. [Laughter.]

Senator Baucus?

Senator BAUCUS. It somewhat reminds me, Mr. Chairman, of something my father used to say to me often—you know, no good deed goes unpunished.

Mr. Chairman, and both witnesses, I would like to explore a little bit the consequences of two separate benefits packages, one so-called standard Blue Cross-Blue Shield which essentially is in the President's plan and second, a catastrophic package.

With respect to how often people would postpone going to the doctor under the catastrophic plan to cover both necessary and unnecessary health care, and what the ultimate costs would then be on the system because of postponed care.

Could both of you just give me your best sense of health care reform with one standardized package on the one hand versus one with both a standard and a catastrophic where people choose one or the other. What are the ultimate costs to society of each option?

Dr. HERDMAN. I assume that under the second alternative where someone chose a catastrophic plan, even if he or she were to need emergency care that he or she would go to the hospital and get it, regardless of whether that person had a high or low cost deductible—or rather regardless of whether that person had standard benefits or catastrophic.

Judy has a fair bit to say about that. I just asked if I could go first because OTA has not really studied this. Of course, the question of the kind of package is a question which is not for us to decide, but you and Congress and the administration.

I would say only this, we did do a fairly deep indepth look at cost sharing. If you consider the catastrophic plan a major cost sharing type of plan, then it is clear to us from the empirical evidence that a lot of care would not be sought by citizens who were subject to this very substantial cost sharing this evidence is reviewed in our report on patient cost-sharing in designing a benefit package which we issued in February.

It is also clear—the evidence is pretty clear—that it is not only unnecessary care that is avoided, but it is necessary care as well that is avoided.

Senator BAUCUS. Can you quantify that roughly?

Dr. HERDMAN. I think there is no reason to suspect that there is any differential in favor of one or the other. In other words, I think that a lot of necessary care would be avoided, but I cannot make it more precise than that.

I think also that—and this is where typical cost sharing may not be so dramatic, presumably, as having a catastrophic plan—that this does have deleterious health outcomes for patients. That is all I have.

Senator BAUCUS. Dr. Feder?

Dr. FEDER. Yes, I think just building on what Dr. Herdman has said, there is a lot we do know, there is care that ought to be provided that is foregone and sometimes more expensive services are

substituted for less expensive services. So somebody ends up in the hospital when if they had had outpatient services the illnesses might have been prevented.

Even though they are going without services, necessary services, some services will be received. Therefore, I think you were raising that problem, Senator Baucus, when you say you will pay for them anyway. You will be left with uncompensated care in that circumstance. People will end up in emergency rooms.

Senator BAUCUS. Well, there are two questions. There are many questions, but there are two that I am focusing on now. One is, assuming the same outcomes, which is a very difficult assumption to make. Is a two package system, ultimately more expensive than a single package or not? That is one question. The second question is: With a two package system, is there very significant cost shifting?

I am assuming that those who are chief catastrophic are going to be the healthier population and they will probably need less care. That is an assumption I make. Whereas, those who choose a standard, maybe get a little older, they are going to be perhaps a little less healthy population and, therefore, their care is going to be much more expensive.

It just seems to me that you are getting into a two-tier system. Then also there will be some cost shifting. Do you agree that a plan has both?

Dr. FEDER. I think that the problems you are identifying would exist. There is a further problem. That is, I think we are talking about across the board, across the range of plans that are being proposed, we are looking at moving the system into a different approach in which there is competition across plans and people are choosing plans; and that that choice would lead us toward a system in which providers are really managing care. That is the way to control costs, not enormous cost sharing, which is what I think Dr. Herdman was indicating.

If you have a catastrophic package along side other packages, you create an enormous cost differential between those comprehensive packages which we think are better able to promote health efficiently and those scaled down packages. And it makes it much harder to move the overall system, delivery system, in the direction I think we all believe will better promote health. That will cost us substantially in the long run and it is an important issue.

Senator BAUCUS. The two package approach tends to cost more in the long run.

Dr. FEDER. Exactly.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

Senator Dole?

Senator DOLE. Am I next?

The CHAIRMAN. Well, technically, yes. And Senator Danforth is next. You are a very generous leader.

Senator DANFORTH. Thank you very much, Mr. Chairman.

Dr. Feder, I do not want to sound in any way personal or nasty and I hope you do not take it that way.

The CHAIRMAN. Should we clear the room? [Laughter.]

Senator DANFORTH. I think as a matter of fact that as a political strategy what you and the administration are doing is the right thing, namely to fuzz up the issue. But that is what you are doing.

I have looked through your statement, and I have listened to your statement, looking for some hint that there are hard choices that will have to be made as to what is on and what is off the defined benefit list. There is not the slightest indication that there are any hard choices. There is not the slightest indication of anything being left off.

In fact, on page 2 of your statement—well, actually the section starts on page 1, "Health Security Act, Comprehensive Benefits Defined in the Statute." Then you turn over to page 2 and the word "comprehensive" is in dark, bold type, twice. And you say, "Finally, we must ensure access to comprehensive benefits to avoid the creation of a two-tiered system where the wealthy may be able to afford a good benefit package."

Now I read this to say that everything is on the list, that there is no indication at all that anything is off.

When Mrs. Clinton testified before this committee I had just one question I wanted to ask her, and it pertained to the Baby K case, the child who was born without a brain, and who is being kept alive at a cost of several hundred thousand dollars I think. I said, would Baby K be covered and Mrs. Clinton would not answer that question. That was the politically wise thing to do.

Let the American people think that everybody is going to be happy, that nothing is going to be excluded, that nothing is going to be left off the list. But it is a disservice to the American people to create that impression because the impression is not true.

We cannot have health reform that is responsible if everybody is happy, if everybody ends up having every treatment. So I would like to ask you if you can give me some examples of what you believe would be left off of a list of defined benefits.

Senator ROCKEFELLER. If she does not, I will.

Senator DANFORTH. Good.

Dr. FEDER. Senator Danforth, I would like to raise a question as I did at the outset of my remarks about the overall perspective on limitations and hard choices in this system.

The issue has to do in my view, and it is not—I am not just an official in this administration. I have been doing health services research for 20 years. The issue goes well beyond what benefits are specified. The issue as to what people get in this system, as Dr. Herdman was emphasizing, has a great deal to do with the way in which the health care system is operating and the incentives in that system.

Whatever benefits you specify, an issue remains as to what is paid for, what people get and what the incentives are. We have a wealth of experience that tells us that in a system that is essentially one in which no one, no providers, are held accountable for efficient delivery of quality of care, in which insurance plans are focusing on avoiding risks, rather than managing efficient delivery, that essentially we have a continuing flow of dollars.

It is our judgment that the way to address that issue is essentially to change the incentives in the system.

Senator DANFORTH. Dr. Feder, like Mrs. Clinton, as was the case with your statement, prepared statement and your oral statement, you have told me absolutely nothing. This hearing is about a subject. The subject is the defined benefit package. You have given me no indication, not even the slightest hint, as to what would be off of the defined benefit package.

Now could you give me some examples of what would be off of the package?

Dr. FEDER. I can, Senator.

The CHAIRMAN. Take your time. We have plenty of time.

Dr. FEDER. All right.

The CHAIRMAN. We do.

Dr. FEDER. There is a list of exclusions. There are custodial services, I believe, are not included. We are phasing in adult dental coverage, the mental health benefits are—here, I can read it to you. Thank you.

Custodial care, cosmetic surgery, hearing aids, eye glasses and contact lenses for adults, invitro fertilization, private duty nursing, personal comfort items and some additional dental services, and some other services.

Senator DANFORTH. If I could, Mr. Chairman—I know I am over my limit—you have not gotten to the question of the Baby K situation. You have not gotten to the question of liver transplants for people with sclerosis. You have not gotten to the question of kidney dialysis for people over 55. You have not gotten to the question of neonatal care for babies under 1,000 grams.

Are these not the kinds of questions that would have to be faced by any group putting together a defined benefit package?

Dr. FEDER. I do not believe so, Senator. I believe——

Senator DANFORTH. You think all these are covered?

Dr. FEDER. I believe that I have gotten to those issues and I respectfully submit that we simply disagree on what the appropriate answer is.

Senator DANFORTH. All right. Then your answer is, all of these things are covered.

Dr. FEDER. My answer is that the way to promote quality care efficiently delivered is to change the way in which health plans and providers and consumers are operating in this system, and to leave those decisions in the hands of physicians who are actually working with patients and circumstances and can best make those in an environment in which the incentives are to promote efficient delivery of quality care.

Senator DANFORTH. Mr. Chairman, I would simply say to you that if the courage of the Congress of the United States has finally gotten to the point where we really suck it up and keep hearing aids off of the defined benefit package, we are going nowhere, absolutely nowhere. We have ducked, and dodged, and bobbed, and weaved, and avoided the economic question and the ethical question that should be before this country.

The CHAIRMAN. Well, it is before this committee, Senator, not in the least thanks to you, and we are not going to go off the subject until we have some satisfaction.

I think Senator Rockefeller has a different view and we welcome that, sir.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Or a partially different view, anyway.

Senator ROCKEFELLER. I do not find anything particularly offensive about writing in small darker letters the word "comprehensive" twice on page 2. What I do find important, Senator Danforth, is that what Judy Feder was trying to say is that any service that is not medically necessary or appropriate will not be included.

That is not always the decision of a Board or of a Congress. You and I have worked together on those 7,000 people who are comatose and listened to their spouses plead for us to make a decision. You and I have worked together on living wills and durable powers of attorney and advanced directives which are now out and about in public institutions.

But you cannot take from doctors certain decisions. I agree with you. I understand your rage, because you want solved the 7,000 comatose people who are costing hundreds of thousands of dollars a year to keep alive and whose spouses appear weeping before us saying nobody will take my spouse out of his or her misery.

But in a defined benefit package where the standard is any service that is medically necessary or appropriate and then a whole number of specific exclusions are listed—incidentally, if you do not think not having adult dental care matters to some people, you are wrong. They care enormously. They will not get it. We will tell them, at least I will, no. Children, yes; adults, no. I have no difficulty doing that.

What I find really offensive are plans that say as Senator Baucus indicated, well, you can have catastrophic or you can have a basic benefit package which automatically heads everybody off towards catastrophic, which is not only cheaper, but where all the healthy people go. Which means you get right back into the risk selection business.

Tom Pyle made the point at the Tuesday hearing that no HMO plan could compete with a catastrophic plan with $1,000 deductible. A plan that says, we will not even talk about what will be included or what will not be included, we will leave it up to some future Board, assuming that the Board members are pure and perfect and decent, whereas we are indecent, imperfect and without any spine whatsoever.

I have some spine. I can say no. I have done it plenty, as a Governor and I have done it as a Senator. And I can do it on health care because I need to, because we have to be able to figure out what we are going to pay for this thing.

But, if, as in the Chafee plan and the Cooper plan, nothing is defined as to what is to be on the benefit package, nothing, it is like saying, sign the insurance policy and then we will figure out later what you are going to get. Nobody would do that. Nor should we in Congress.

How can you possibly estimate the cost of a health care package if you do not know what the benefits are. Now you may disagree with what the benefits are and want to take some of them off, but at least put in what should be included, because it is off of that benefit package that the costs, and the analysis of the costs, and the implication of the costs are built. And the Chafee plan does not

do that; and the Cooper plan does not do that. The Clinton plan does do that.

So I think, you know, facing up to hard choices, I agree with you. I want you to face up to the hard choices of the baby that you indicate. But I do not think we can do that in a legislated plan. I think that is where a doctor's decision has to come in and I think you and I have to work together to make sure that ethics are taught more at medical schools than they are today; and they are beginning on that.

But to have no defined benefit package to me is extraordinary. That is not a matter of no fine print, that is a matter of no print whatsoever. I think that has large moral implications. Putting myself in your good and moral mind, I would be offended by that. You are saying to the American people pay for something and have your Congress vote for something that you do not know not what is in it or what the costs are or what the benefits are or what they are not. That is not a question, Mr. Chairman.

Thank you.

The CHAIRMAN. It is a perfectly proper statement.

Does Senator Danforth want to respond?

Senator DANFORTH. I think, Mr. Chairman, that we have joined issue on this. I can remember years ago when Senator Weicker was in the Senate he offered an amendment to provide some expanded treatment for AIDS patients and I raised the question on the floor of the Senate at that time, should there be any limit to what we are willing to spend to keep somebody alive for an additional 3 months.

And his answer, and it was stated with great fervor, was no, no price tags should be put on it. I do not agree with that. I mean I think that what we are doing is really ducking the issue. I believe that politicians are never going to successfully keep things off of a list. I believe that the first time there is an actual case that tugs on the heartstrings, the TV cameras are going to be at the front door of the affected family and people are going to show up in our offices and we will end up saying, oh, this is going to be in or that is going to be in.

So I believe that it is important to have some commission, but I also believe that it is important to say, as Oregon has tried to do, there are at least some things other than dental care or hearing aids that are just not going to be done in the standard package, even though they may be effective, that they are just not going to be done. I hear none of that.

I hear nothing other than a ducking of this fundamental issue.

The CHAIRMAN. All right. But you surely would agree that science has created a Promethean problem here. We are able to do things technically for which we have no ethical agreement, we have no ethical experience. The species is up against something new.

If I could just say, Senator Rockefeller, on Monday Mrs. Clinton very generously visited Kings County Hospital in Brooklyn, our great municipal hospital in New York City. We were in the neonatal ward. There were children there who I am almost certain—I will confirm this before the morning is out—arrived at weight below 1,000 grams and they were alive and they will live.

Fifteen years ago they would not have even arrived. So there you are. And 1,000 why not 999 or 1,001? As adults I am sure Dr. Herdman recognizes that this is a problem that is a new one to the species.

Dr. HERDMAN. Well, below 1,000 grams there is fairly decent survival.

The CHAIRMAN. But I mean the whole question of things that medical science could do today, that did not arise in your medical training, I suspect.

Dr. HERDMAN. Of course.

Senator ROCKEFELLER. Mr. Chairman?

The CHAIRMAN. Yes, sir.

Senator ROCKEFELLER. I just want to say one point about the moral implications of what is or is not on the list. When Sharon's and my first child was born, after 2 weeks, after a week he started—1 week of life—he started projectile vomiting. That scared us and we did not know what it was.

When it continued, we took the boy to the hospital and they said he had something called pyloric stenosis, which happens with boys more than girls—I think exclusively with boys—which means that there is a narrowing of the esophagus into the stomach. So they operated.

I think when I read the word "any service that is not medically necessary or appropriate" that we can, while we specifically exclude popular pressure type items, for example hearing aids, et cetera, that we should not be reading that pyloric stenosis is specifically included. That is what comes under the judgment of a doctor and I do not think we can suddenly say that doctors cannot have judgment.

That is a doctor's judgment, that it was medically necessary, and it was done. But I think if I read that in the list of defined benefits it would be absurd.

The CHAIRMAN. Right. I was just handed a note that in Kings County babies with as little as 1.5 pounds, some 600 grams, can be helped to grow and have minimal neurological problems at great cost, but it is now possible. This is what we are here for.

Senator Dole, you have been very patient with us.

Senator DOLE. I have learned a lot. This is going to be a very difficult area, whether you are going to have a commission or specific benefits. I think in the Chafee bill it defines medically necessary. It is not in the Clinton proposal. Defined is, anything that improves the quality or length of life. So there is some difference there.

But I would underscore what Senator Danforth has said. It seems to me and it seems to a lot of people I talk to, and these are not at Republican rallies, how can we have all the new entitlement programs, whether it is early retirees, prescriptions, long-term care, anything else that anybody may want with a few exceptions and still say we are going to save money.

I mean it is a case that is very hard to make and I think that is one reason that the support for your bill is dropping like a rock. It is not because of these "millions of dollars" being spent. The administration has spent 10 times as much the last year in many ways to promote their plan. But the American people know it is too

complicated. They do not understand it. They do not comprehend how you are going to save all this money when everybody gets everything in it.

But getting back to the specifics, could I go outside under the President's proposal—could I go outside of the alliance to buy coverage for something that is not covered?

Dr. FEDER. What you as an individual do with your own dollars is your choice?

Senator DOLE. So I can go out and buy a catastrophic plan or medical savings account?

Dr. FEDER. The issue is—I answered you in terms of the services purchased. You can also buy supplemental coverage for services not covered in the guaranteed package.

Senator DOLE. Another question we always as members of Congress are asked. Are members of Congress going to have the same benefits as everybody else?

Dr. FEDER. In the President's plan, yes.

Senator DOLE. How does that happen?

Dr. FEDER. Essentially they—[Laughter.]

Senator DOLE. I am just trying to find out. We are asked that question a lot.

Dr. FEDER. In the President's plan members of Congress, like all Americans, are guaranteed a package of coverage and they purchase it very much the way many of them do now, through the Federal Employees' Plan. Essentially, we are extending those choices to everyone. You make them in the community in which you live.

Senator DOLE. And do you still have all the choices you would have under the Federal plans?

Dr. FEDER. We think of it as extending that choice that members of Congress now gets to all Americans.

Senator DOLE. So when somebody asks me in a town meeting I can quote you?

Dr. FEDER. You certainly can.

Senator ROCKEFELLER. Senator Dole, I think she has answered that incorrectly. Can I try to be helpful?

Senator DOLE. Yes. I want to get a straight answer because I have seen these bumper strips—will I get the same benefits as you?

Senator ROCKEFELLER. Yes. The point of the Clinton plan is that the President, the First Lady, the Congress, the members of the Cabinet have no health care coverage which is different than any other American, the opportunity for health care coverage.

The CHAIRMAN. Now I have to interject. They get the health care from the alliance.

Senator ROCKEFELLER. That is correct.

The CHAIRMAN. Not every alliance has the same provisions.

Senator ROCKEFELLER. Yes.

The CHAIRMAN. So it is not true that it is uniform to every American.

Dr. FEDER. Could I——

Senator ROCKEFELLER. Well, I did not finish correcting you, Judy. [Laughter.]

Dr. FEDER. Sorry.

Senator ROCKEFELLER. I do not think, and tell me if I am wrong——

The CHAIRMAN. Senator Rockefeller is recognized and not on your time.

Senator DOLE. That is all right. Go ahead.

Senator ROCKEFELLER. If I am wrong, then I want to know that, because I have been giving them the wrong answer. My understanding of it is that the Federal Employees' Health Benefit Plan, in fact, ceases to exist. It does not continue, which is what Dr. Feder said, that it would continue. Which is what I thought she said, which I thought was misinforming you.

But it is a model for what alliances would be. So I think it is very important to say that it stops existing. It does have more choices than most other Americans have under the present circumstances and we would be in the same situation with all other Americans and we would be in alliances.

Dr. FEDER. Thank you, Senator, for the clarification.

The CHAIRMAN. The distinction is that everyone would be in an alliance, not that every alliance would have the same provisions. That is an important distinction.

Dr. FEDER. Well, if I could clarify that. I appreciate Senator Rockefeller's clarification that it is a model like the Federal Employees' Plan that we are extending to everyone—Members of Congress and others alike.

Mr. Chairman, with respect to the coverage that is offered in each community, the guaranteed package——

The CHAIRMAN. The benefits will be the same as under the statute.

Dr. FEDER. That is correct.

The CHAIRMAN. Senator Dole, you have another 5 minutes.

Senator DOLE. But does that phase in immediately? Does the Federal plan terminate or phase out?

Dr. FEDER. In 1998 is when the Federal Employees' Plan would be essentially eliminated because that is a time period when it could nationally be absorbed in the rest of the system.

Senator DOLE. I think it is dealt with in nearly every other proposal, too. But I think it is a question that there is a lot of interest in because a lot of people believe we are going to have a special plan and they are going to have a different plan that is going to contain fewer benefits. That is not going to be the case under the Clinton plan or I think under any of the other plans, or most of any of the other plans.

What happens in the case that under any benefit package—maybe it goes back to the definition, maybe it is up to the doctor, where you have tried everything and there is some new drug out there, an experimental drug. Is that going to be a determination made by the physician that would not be precluded from anything in the Clinton proposal?

Dr. FEDER. Investigational treatments are covered when they are part of clinical trials. That is similar to the way some of that is done today. And otherwise, plans may cover experimental services. They are not required to do so.

Senator DOLE. Right. They may cover it. But again, it would be a decision, I guess, finally with a physician and the patient. Right?

Dr. FEDER. That really becomes a decision on that specific when something is experimental so that it is not automatically included as medically necessary or appropriate. That essentially becomes a decision by the plan, which is the overall mechanism—the practitioners as well as the insurer.

The CHAIRMAN. Thank you, Senator Dole.

Senator Durenberger?

Senator DURENBERGER. Thank you.

Your comments on the visit to the neonatal intensive care unit reminded me I went to a similar one in a Sioux Falls, South Dakota hospital recently with 26 kids and 26 beds. I asked the doctor who headed the unit, if there is just one cost-free thing we could do to reduce the number of 600 to 1,000 gram kids in here, what would it be, and he said smoking cessation would cut it by 25 percent.

Senator PACKWOOD. Smoking?

Senator DURENBERGER. No smoking would cut it by 25 percent.

The CHAIRMAN. Good God.

Senator DURENBERGER. That may be apropos of nothing other than a question I am going to lead up to, but it really is a very important issue to make in a system which has many influences to it.

Secondly, for those of us, particularly up here, the discussion started by our colleague from Missouri was most apt, but it reminded me to remind you if—and you may well be aware of it, that 11 years ago Stan Kimits, then 32-year-old doctor's son slipped off a curb in downtown Washington, DC, was hit by a car and today he's 43 years old, but he has been comatose for 11 straight years.

I was recently at a meeting of gastroenterologists—it must have been all 3,000 of them in the country up in New York. When we got to the question and answer part of the meeting, one doctor stood up in the back of the room and he says, all that talk about markets and managed competition he says is nice. He says, you may believe it, but it is not going to work.

He says the reason is, you cannot put prices on medical products and services. I said at the time, doctor, if you do not put a price on what you do, the rest of us cannot put a value on it. And if we cannot put a value on it, we cannot change the system. We cannot deal with medically appropriate. We cannot deal with the ethical issues and we cannot deal with the issues of experimental therapies for which some HMO recently lost an $83 million law suit, if you will.

Those are three critical issues. Jack brings them up. They are appropriate. But I have to tell you——

The CHAIRMAN. Do you want to say them once again? This is important. The three?

Senator DURENBERGER. The three issues?

The CHAIRMAN. Yes.

Senator DURENBERGER. The three issues relate to what is medically necessary or medically appropriate or whatever the language is that I think we have a basic agreement between the Chafee bill, Clinton and so forth, describes the kind of benefits. The second are the ethical issues or the moral issues or whichever we decide that

Jack brought up and Jay so carefully and accurately responded to. And the third are the issue of experimental therapies.

Just because somebody found something that may have worked once, is it now because of the pathos of all of this, is it to be applied to everyone. Those are three terribly critical issues. But every one of them is presented—to use the medical term, which is the only medical terms I think I understand—in this issue of the basic benefits.

I do not even want to ask the question about why are we here today. I want to try to respond to it in my own terms. A basic benefit has three functions. I just do this to try to be real simple about it. One of them is, to make markets work.

The basic benefit did not begin with this 58-page list of services. The basic benefit is in the small group insurance reform bill because you cannot compare one product with the other for purposes of guaranteed issue, guaranteed portability, underwriting reforms, any of that sort of thing unless you can compare one product with the other.

So the first important function of a basic benefit package or whatever we call it is comparability, so that we are better informed choosers of this product we call accountable health plans or health insurance.

The second is equity. That gets to the issue that Jay raised about we cannot estimate costs. Equity is a redistribution of income in a society which helps the healthy pay for the sick, the wealthy pay for the poor, whatever that issue may be.

That is the issue that we struggle with on universal coverage. How can we make this remodeled reformed health plan more affordable for everybody in the country to get the universal coverage? But that is an equity issue which markets cannot help us with. Markets can help us get the costs down, but they cannot do equity.

But in there, you know, we struggle with what do these benefits costs. I just want to say here, there is no way with the knowledge exhibited here today or 2 weeks ago by Bob Reischauer, there is no way we can estimate the costs in America today of universal coverage over the next 5 to 10 years.

The third issue is the issue—and this is the one I want to get to—is value judgments. What are we getting for our money? Stay healthy. Correct diagnosis. Do it right the first time. A therapy that will work and get you back to work quickly. Productivity measures, things like that.

That is a value judgment which is in part incorporated into the design of a benefit package and in part is left—and here is where I want to get to my question—only to a health plan, only to a health plan. It is not what is in this package that is so important. It is what is out there in the delivery system that is critical. That is what provides the benefits. I do not buy that thing over there. I buy a particular service in a particular community, which has a particular value to me and I pay a special price.

If you put a rich package, a 58-page benefit package that the Fortune 500 gets down on an undisciplined marketplace you are going to break the bank.

I am going to ask all my colleagues to read the latest—I usually do not do this—but I will ask you read the New England Journal

Medicine, an article on page 607. It is on physician profiling in which they compare Florida physicians—I wish Bob were still here—and Oregon physicians.

The CHAIRMAN. He will be back.

Senator DURENBERGER. Right. They did this, this is 1991 data for a large number of—and this is all Medicare, so we are dealing with a lot of older people. It takes into account the relative values adjusted for physician case mix and the influence of the physician specialty. So it tries to be as neutral as it possibly can be.

What is the conclusion? It shows in effect that Oregon is about one-half the national mean for use of something like CT and MRI and Florida is 50 percent over the national mean. What does that mean? Simply that when you put CT and MRI and so forth in there, you are going to use three times as much in Florida as you are going to use in Oregon.

The CHAIRMAN. Do you want to restate that just for one moment? [Laughter.]

Senator DURENBERGER. Well, Bob may already know this. But in the latest issue of the New England Journal of Medicine there is a report of study comparing the application of physician services in Florida and Oregon. And among other things, it shows that the Florida physicians all use many more resources on the average person and on the average than do their colleagues in Oregon.

It means they use a lot of technology. They use a lot of hospitalization, all the rest of that sort of thing. Just to use one example, Oregon is one-half the national average of the national mean in its use of CT and MRI and Florida is 1½ times.

What the bottom line of that is, when you put that in there in an undisciplined market, Medicare will pay three times as much for the same people doing the same sort of thing in Florida as they do in Oregon.

So, Mr. Chairman, I raise this because some of us in sort of the middle of this debate are arguing that 58 pages of services is going to break the bank. Six pages describing a benefit in a different way and then leaving to a commission a way in which to make those benefits real, and then leaving it to accountable health plans to prescribe the services is much more important.

I know this is an incredibly difficult subject, as Jack and others have pointed out. But it is also very important for all of us to remember, that if we try to get service specific in that health plan, we are not solving our political problems because they are all out there lobbying us. Every year when this plan comes up we are going to have more people lobbying us to make sure that they are included under medically necessary and medically appropriate.

We need to deal with the realities that those benefits needs to be an ongoing process of change that reflects the reality of what services work and what services do not work in the real market.

The CHAIRMAN. Senator Durenberger, the next panel is going to be asked to address those three questions you had.

Before Senator Dole has to leave, could I just say, Dr. Herdman, did I not see you nod when Senator Durenberger said it really would be impossible to estimate the costs of universal coverage?

Dr. HERDMAN. Mr. Chairman, we have been asked by our Board and by Senator Stevens to look at the assumptions and documenta-

tion behind health care cost projections for various reform plans. We did some early work and we are in the process now of doing a more definitive piece, which I hope will be released shortly.

I hasten to say that I do not think we are in disagreement with Mr. Reischauer; our conclusion is that these are speculative and the bounds of uncertainty are large. So it is very difficult to say that any given figure is a true figure.

The CHAIRMAN. Fair enough. A final question——

Senator ROCKEFELLER. Mr. Chairman?

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. I am being pesky.

The CHAIRMAN. Well, you and I are half this panel today.

Senator ROCKEFELLER. But I am about to leave, you see, so that is the trade off.

I understand that it is difficult to estimate do universal coverage because we have not done that to health care in America before.

The CHAIRMAN. To estimate.

Senator ROCKEFELLER. Sure. On the other hand, I want to make the concomitant point that it is also difficult to estimate the cost of, you know, unmentioned coverage, of a blank slate. That is also pretty difficult.

I would rather take a shot at trying to estimate universal coverage and be off by 5 or 10 percent and then come back and adjust that, than to have no explanation of anything in the way of benefits. It is merely a point.

The CHAIRMAN. I want to state to you that there is an iron rule of social science, which is that if you put a number on something, you already know more than you did beforehand.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Ms. Feder and Dr. Herdman, is it not true that you have to have a uniform benefit package to prevent risk selection? Absent that you are going to have risk selection. Somebody will tailor a plan for the young and healthy; somebody will tailor a plan for expectant mothers and so forth and so on.

Dr. FEDER. I think you are absolutely right, Senator.

Senator CHAFEE. Agreed?

Dr. HERDMAN. Yes, sir.

Senator CHAFEE. So this subject does come up. There are some here in the Senate that believe you should not have a uniform benefit package. The corollary to that is, if you do not have it, you are going to have risk selection, which you just answered in the affirmative.

Do I understand in the administration's plan that supplemental benefits—now the way I define supplemental benefits, and I think you do too—is something beyond the uniform benefit package. Let us say it is orthodontics or whatever.

Under the administration's plan, supplemental benefits can continue to be offered and will continue to be tax deductible until year something or other. Is that correct, Dr. Feder?

Dr. FEDER. That is correct. Essentially, benefits can be provided more broadly and there is only a change in their tax treatment in the future. That is correct.

Senator CHAFEE. Which is what, 10 years out or something?

Dr. FEDER. I believe it is 2004, but I will double check it.

Senator CHAFEE. All right. We do not have that in our plan, as you know. We believe that if somebody wants supplemental services, three cheers, they can have them. But they have to pay for them and it is nondeductible, which you eventually get to. In other words, if somebody has the supplemental benefit, they can get it, I presume, under your plan.

Dr. FEDER. Yes.

Senator CHAFEE. But it becomes nondeductible after the 10 years. And nondeductible, if the employer offers it, I presume it is nondeductible by the employer and taxable to the employee. Am I correct in that?

Dr. FEDER. Yes. Our change in tax treatment applies to the individual side, where we leave the employers neutral between health benefits and wages. The application is on the treatment for tax purposes of the employer paid premium for the individual.

Senator CHAFEE. Let me see if I can understand that.

The CHAIRMAN. I understood that perfectly.

Senator CHAFEE. Well, that is why you are Chairman. [Laughter.]

The CHAIRMAN. After the 10-year period, if Ford Motor Co. should offer eye glasses which are not covered for adults under your plan, that would be deductible by Ford as a business expense, but the cost of that is that taxable to the employee?

Dr. FEDER. The premium contribution made by the employer would be treated as income to the employee for tax purposes.

Senator CHAFEE. Taxable income. In other words, it is a taxable fringe benefit.

Dr. FEDER. Yes.

Senator CHAFEE. All right.

Well, let me just finally say I believe there is great merit in the provision we have in our plan for changing the uniform benefit package, whereby the Benefits Commission, which is composed of wise men and women and selected with certain requirements, that they be knowledgeable in this field and so forth.

We provide that recommendations for two uniform benefits package come to the Congress on an up and down vote, just like the base closure package. In the base closure experience we found there is a minimum of log rolling, there is a minimum of tradeoffs between one Senator keeping his base, voting for the other fellow in a swap. In other words, both bases will be kept open. Absent the base closure arrangement, where you can only vote yes or no and probably no bases would be closed.

So we carry that over into the uniform benefit package, that the details are presented to Congress. Congress votes yes or no. Absent that procedure, we feel it could become the richest benefit package conceived by man or woman.

Now how do you avoid that under your plan? Because Congress would get its hands on the benefits under your program would they not?

Dr. FEDER. Essentially, as you said they would, Congress would approve the Board. We would have it specified in the legislative language, the benefit package.

Senator CHAFEE. So when the legislative language comes before Congress, and you have 68 pages or whatever it is, and you leave out eye glasses; as you say specifically you do; all Congress has to do is by a majority vote put eye glasses in, is that right?

Dr. FEDER. In dealing with the overall package, in guaranteeing security of coverage, we think it is incumbent upon Congress to identify what it is that people are covered for, and what it is we are getting, and what it is we are paying for. That is right.

Senator CHAFEE. Well, my time is up.

The CHAIRMAN. No, no.

Senator CHAFEE. I just think that that is a proposition that—well, let me rephrase it. When you leave it open to Congress by a majority vote to add something, it will be added. And your package; which has been described by Senator Danforth as not keeping anything out; by the time Congress gets through, anything left out will be added.

Dr. FEDER. Senator, our view is that—and it gets to some of what Senator Danforth was saying earlier—is that we believe that the administration and the Congress are engaged in addressing the hard choices—that is, guaranteeing everyone security of coverage in an affordable manner.

And, consequently, we think that as putting this package together in a fiscally responsible fashion that provides protection requires that we address what it is that American citizens can expect, how it compares to their coverage today, what they are getting and what they are paying for.

So we believe that the Congress is accountable for that and that it is best and appropriately and only fairly addressed in the legislation.

Senator CHAFEE. Well, we have a different opinion there because you have more confidence in the restraints of Congress than I do.

The CHAIRMAN. But do accept it as a compliment. [Laughter.]

Dr. FEDER. It was intended as such, Mr. Chairman.

Senator CHAFEE. Thank you very much.

The CHAIRMAN. Thank you, Senator Chafee.

Thank you, Dr. Feder. Thank you, Dr. Herdman. This has been a very helpful morning. As you can see, we are trying to think our way through this, if that is the way to describe the process. But we are learning.

Dr. FEDER. Thank you, Mr. Chairman.

Dr. HERDMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Herdman, when you have that study that Senator Stevens has requested of you, obviously, you will send it around to us.

Dr. HERDMAN. I will make sure that you have it.

The CHAIRMAN. Fine.

Very well. Now we have a panel of practitioners from across the country who have had to make these decisions and can tell us more about them.

May I say, incidentally, that Mark Blair has the chicken pox. That is why Darcell Savage has to do everything. They still have chicken pox at this stage in the world.

Our panel consists of Susan Gleeson, who is the executive director of Medical and Quality Management of Blue Cross and Blue Shield, based in Chicago. Ms. Gleeson, we welcome you.

Rhoda Karpatkin, an attorney on behalf of the Consumers Union. Ms. Karpatkin is from Yonkers. We welcome you.

Dr. Frank McArdle is the manager of the research office of Hewitt Associates. Good morning, Doctor.

Do you want to welcome Ms. Sipes-Metzler?

Senator PACKWOOD. I would like to very much, Mr. Chairman. I might make a comment the Chairman has made about the frustration we have had with the panels. I do not think we have had a weak witness in all of the hearings we have had and we take the first panel and keep them here until a quarter of 12:00 or thereabouts and then bring on a second panel.

I want to introduce Paige Sipes-Metzler and tell you just a little bit about the Oregon Health Commission. She is the Executive Director of the Commission that set our priorities, if you want to call them that. And she was there, in fact, 6 weeks after the Commission was put together.

So she was there when we started the list, went through a variety of hearings, saw the list rejected once as I recall, had to go through it again, had a terrible time with the Department of Health and Human Services in getting the Bush Administration to approve it. They finally did not, but this administration did.

And now the Commission is ongoing and reports to the Legislature every 2 years as to whether the list ought to be changed; and the Legislature says we have more money or less money. Whatever they say will only go so far down the list.

But to the best of my knowledge, it was an effort to answer the kinds of questions that Senator Danforth put forth. We have not got enough money for everything. So here are specifics. We will cover Procedure X; we will not cover Procedure Y; we will cover Z; we will not cover A. We are sorry, folks, but that is all the money we had.

Paige is an R.N. and she has a D.P.A. in addition and as I say has been with it from the start. She knows the public hearings we went through. She knows the bilingual translations we attempted to get people to come, and provided babysitting services so people could come—57 hearings as I recall—and did everything conceivable to get consumer input, physician input, hospital input, labor input, aged input into this; and I think did a whale of a job and I am delighted to have her here.

I might say, Mr. Chairman, I am embarrassed. I am going to stay as long as I can, but I am leaving for Oregon today and I may have to go before the panel finishes.

The CHAIRMAN. I know. You told us that a week ago. So let us get going. And if the panel will not mind, I would like to ask Dr. Paige Sipes-Metzler to go first in case you do have to leave.

Senator PACKWOOD. Thank you very much, Mr. Chairman.

The CHAIRMAN. We have been talking. He has been bragging on you for the last 4 weeks. So we are tired of it. Then Senator Durenberger started producing data from the New England Journal of Medicine, which you heard, which confirms what he has been saying. It is all getting a little suspicious. Good morning, Doctor.

STATEMENT OF PAIGE R. SIPES-METZLER, D.P.A., EXECUTIVE DIRECTOR, HEALTH SERVICES COMMISSION, OREGON DEPARTMENT OF HUMAN RESOURCES, PORTLAND, OR

Dr. SIPES-METZLER. Good morning, Mr. Chairman and members of the committee. I appreciate this opportunity to express the State of Oregon's recommendation for the adoption of a commission structure in the process of developing a standard benefit package.

This recommendation is based on Oregon's experience with the use of a commission. When the consideration of a commission occurs two variables are critical in this consideration.

The first is the selection of its membership and the second is the size of the commission. Members, or the individuals selected to participate, must have knowledge of the issue—in this instance, health care and the designation of benefits. And secondly, they must be able to work for the common good and put aside personal interest or agendas.

The size of the commission should also be small—less than 15 people and an odd number. This size allows for diversity among participants while it is small enough to reach consensus. This size also encourages the use of small task oriented work groups that increase the opportunity for the public advocates and experts to provide information while ensuring a uniform decision process and understanding by that commission.

Oregon has found that commissions that have several unique characteristics are more successful in the eyes of both the legislature and the public. These characteristics are the ability to communicate, the ability to listen, accessibility, and a responsiveness to concerns. These Commissions are more acceptable even if their answers are more controversial or may not be what every consumer wanted.

They need to be neutral or apolitical. This neutrality enables them to blend different political agendas and come up with a mutually acceptable compromise. Third, they need not be financially responsible for their charge. By this I mean they need to focus on the policy recommendations and not have their recommendations biased by financial considerations.

Then last, as I mentioned earlier, the use of smaller task oriented work groups allows a greater opportunity for more participation by a wide number of people or persons.

Commissions are not without political weaknesses. The selections of the participants without knowledge or participants with special agendas can result in internal friction and lack of consensus. Lack of clear mandates or intent from the legislature, expansion of mandates or the unclear focus of a commission will allow them the opportunity to flounder without reaching any effective outcome.

Lastly, a commission itself could become a political body and, therefore, work to expand the commission as a life and reduce its effectiveness.

Oregon, perhaps through the identification of potential weaknesses, has found that a commission is most successful as an avenue for blending public values with scientific fact and reducing the political debate about in the legislature which Senator Chafee has been talking to small, very focused details regarding allocation of resources.

In this manner, the final outcomes that have been reached through the interaction of a commission and the legislature have been acceptable to the public. Also from a State's perspective, a commission offers simplicity in allowing States the opportunity to pursue their own programs by demonstrating that they have satisfied legislative intent instead of the administratively complicated, complex and time consuming activities that are required in seeking Congressional waivers or amendments to Congressional statutes. In that sense, we would encourage the use of a commission to allow States that opportunity.

In summary, I am expressing the recommendation for the use of a commission structure in the development of a standard benefit package due to its ability to be timely in its response to public concerns and medical technology, its ability to maintain an apolitical nature, and last, the ability to achieve its stated goal.

Thank you.

[The prepared statement of Ms. Sipes-Metzler appears in the appendix.]

Senator PACKWOOD. Could I make a comment also, Mr. Chairman?

The CHAIRMAN. Not before I say, do you realize that Dr. Sipes-Metzler finished before the bell rang. [Laughter.]

You have a Doctor's in Public Administration?

Dr. SIPES-METZLER. That is correct, sir.

The CHAIRMAN. Do not underestimate it.

Senator PACKWOOD. I might say, this Commission had extraordinary public support. A majority of the Republicans and the Democrats in the legislature supported it; all the statewide elected officials, Republican or Democrat, the AFL–CIO and Associated Oregon Industries, the principal industrial group.

One thing, on two different occasions when Dr. Sullivan, our former Secretary of Health and Human Services was there, and Gail Wilenski, the HCFA Director, they all noted that when they would have news conferences—this was when we were trying to get our Medicaid waiver—even the news media would say, are you going to be able to help us get the waiver. The news media regarded themselves as part of the process. They were not antagonists. Could you help us get it?

So somehow, someway Dr. Sipes-Metzler accomplished this and the Commission accomplished it, and it worked. And to this day it has broad scale, uniform support in Oregon.

The CHAIRMAN. Manifestly so. We are going to go right through. I hope panel members would not hesitate to disagree or comment on other comments.

Ms. Gleeson, you are next.

STATEMENT OF SUSAN GLEESON, EXECUTIVE DIRECTOR, MEDICAL AND QUALITY MANAGEMENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL

Ms. GLEESON. Good morning, Mr. Chairman and members of the committee. I am Susan Gleeson and I am executive director of Medical and Quality Management for the Blue Cross and Blue Shield Association. I appreciate the opportunity to testify here this morning on this important issue of the basic benefit package.

Before I begin, I would also like to take the opportunity on behalf of the Blue Cross and Blue Shield Association and the member plans that we represent to say we are 100 percent behind health care reform. We think health care reform is needed. We think insurance reform is an essential part of that reform and we are very hopeful that we will have effective legislative reform this year.

The focus of this hearing is on the basic benefit package. In our written testimony we have submitted considerations that we would like the committee to look at they formulate it.

The CHAIRMAN. Yes.

Ms. GLEESON. I think what I would like to focus on as part of the oral testimony is the infrastructure and the standardization of the infrastructure that administers the uniform benefit. We have had some discussion of that already by the committee members.

It is not enough to have a standard basic benefit. You also must standardize the definitions, the processes and the procedures of the health plans we use to determine whether a procedure is investigational or not investigational and the guidelines that will be used to determine medical necessity.

Otherwise, you are not going to achieve your goal of equal access across health plans. I mean very simply, if Health Plan A determines something is investigational; Health Plan B determines that same procedure is not investigational, you have unequal access.

Over the years there have been developed processes that are well accepted on how to make the determinations about whether procedures are investigational or not investigation. Blue Cross and Blue Shield was one of the pioneers in this and we would like to give you a little history about our program.

We started back in 1985 and we thought we really needed to do a better job in making these decisions. These decisions are very important because they so impact coverage. We asked Dr. David Eddy, who has a national reputation in technology assessment, to assist us and we told him that we want to develop criteria that we can put in the public domain to explain how we make these decisions.

Second, we want the most objective process. And third, we want a reproducible process. By reproducible, we mean if somebody takes the same evidence uses the same criteria, they come to the same decision. We have been at this for 9 years. We have assessed over 200 technologies and we think that the criteria we use are very valid.

We made some changes back in September and we would like to share those with the committee. First of all, in an effort to conserve health care resources and administrative costs, we are collaborating in this effort with Kaiser-Permanente. Kaiser-Permanente and Blue Cross and Blue Shield are now working together in their assessments of technology, but not in the coverage decision making. We are, however, pooling our critical resources so that we can do more of the assessments.

Second, we have expanded the panel of experts who are the final decision making body. We have a 19 member panel. The majority of these members have no affiliation with either Blue Cross and Blue Shield plans or Kaiser-Permanente.

The CHAIRMAN. But they are medical doctors?

Ms. GLEESON. Yes, they are medical doctors. Dr. David Eddy is an M.D., Ph.D. which has a worldwide reputation in technology assessment. He is our scientific adviser. We have other technology assessment experts from Harvard, Johns Hopkin and Stanford. We have representations from all the major specialty societies. We have experts in clinical areas,particularly those controversial areas like oncology, bone marrow transplant. We have had to deal with issues such as heart transplants for those over 55.

We have representatives and purchasers and we have five members from health plans. This is the body that is making the decision when you see a Blue Cross and Blue Shield decision about whether something is investigational or not investigational.

The third change we have made, and we think this is very important, is to make resources available. We put together a blue ribbon panel to do it and we now make all of the evidence available to any interested party through an annual subscription—other health care plans, consumers, members of Congress.

The CHAIRMAN. In a scientific manner.

Ms. GLEESON. Yes.

The CHAIRMAN. Whatever you have done you put it out in front of the world.

Ms. GLEESON. Right. We think it is not an issue in which there should be any competition among health plans. I think the things that are important here are, we have developed criteria that has been tested over 9 years and the principles have been adopted by the Health Care Financing Administration and other insurers. And what it basically says is, there must be evidence that there is an improvement in health outcome.

As the reform is rethought and reshaped, it would be important not to lower that threshold or that standard. Some of the legislation currently identifies categories of procedures, devices or drugs which categorically are not labelled investigational and are labelled safe and effective, although no one has to speak or show any evidence of safety and effectiveness. What we would be doing by this approach is raising health care costs and proliferating untested, unproven technologies.

Just quickly, I would like to add that we support coverage for increased research into investigational technologies. We put in a program 3 years ago that is separate from coverage, but we are financing high priority clinical trials, particularly in the controversial area of breast cancer and we are going to be expanding that.

Most of the legislation that is written is way too broad. It is an open entitlement program. A process much like Oregon's needs to be put into place on the research issues—where are the high priority research issues and what are the trials that are necessary to get the answers.

The CHAIRMAN. Could I just ask you to clarify for my purposes and the rest of the panel, why do you say investigational? Would not experimental be the term, Dr. Straub? We are trying to produce a lexicon here of what these words mean. I am still struggling with premium. They finally explained to me that premium is the bill.

You know, I always thought of premium bearese, I know about that. But investigational meaning?

Ms. GLEESON. In our contracts we do not use the term "experimental," we exclusively use the term investigational.

The CHAIRMAN. Does investigational mean experimental?

Ms. GLEESON. Yes, it does. They are used interchangeably.

The CHAIRMAN. All right. That is fine. That is all. We can get that under synonyms.

[The prepared statement of Ms. Gleeson appears in the appendix.]

The CHAIRMAN. Now on behalf of the Consumers Union of the United States, one of the most respected organizations of its kind in the nation, in the world, Ms. Karpatkin.

STATEMENT OF RHODA H. KARPATKIN, J.D., PRESIDENT, CONSUMERS UNION OF THE UNITED STATES, INC., YONKERS, NY

Ms. KARPATKIN. Thank you very much, Senator. Thank you for inviting us to testify today. We are the publishers of Consumer Reports magazine and for more than 55 years have been trying to help consumers make sense of the product and service marketplace in the United States.

Like many members of this committee, Consumers Union's effort in support of health care reform go back many years. I brought with me today a copy of the February 1939 issue of Consumer Reports. It is tattered and yellow, but it is real. It is not a reprint. What we said then was, and I am quoting, "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is how soon."

The CHAIRMAN. Fine. We will place that in the record following your testimony. Now we have some idea about how soon. Yes, 45 years ago.

Ms. KARPATKIN. We think the answer should be now. I have nine points I hope I can make quickly within the time limit. First, consumers want comprehensive health care benefits. We commissioned a Gallup survey in April 1993. Close to the 90 percent of those polled favor universal access to a comprehensive health plan, that includes doctor care, hospitalization, prescription drugs, well-child visits, immunizations, nursing home care, long-term care at home,mental health treatment, dental care, prenatal care and vision care.

There was a recognition on the part of the people polled that, of course, that benefits needed to be phased in over time. The preference there was for a period not in excess of 4 years.

Second, consumers need comprehensive health care benefits. The private market is not up to this important job. Indeed, if it were, we would not be sitting here today. In order to achieve true health security, benefits must be comprehensive. Each family has its own unique profile, its own unique needs in the health care area.

The private insurance market has shown us clearly that it is not designed to come to your assistance when you need help. It is designed to maximize profits for insurance companies.

The cliche that you cannot buy fire insurance when the barn is already burning applies to health insurance. Once a family needs long-term care or insulin or chemotherapy, insurance companies prefer not to take your call.

Third, Cadillac health coverage is a myth. There has been some discussion recently of the need to avoid Cadillac health care protection in favor of more modest coverage. Medically necessary care is not Cadillac care. If you need insulin, is prescription drug coverage a frill? If your mother has Alzheimers Disease, is long-term care for her deemed to be Cadillac coverage? If your child is manic depressive, is mental health protection the Cadillac? When people cannot afford to pay for a measles vaccination for their children, would that be scaled back?

Fourth, Congress should not leave the design of the benefits package to a benefits commission. A reform bill with an unspecified benefits package does not make sense. You simply do not know what you are getting. Consumer Reports would never recommend that a consumer buy any insurance policy without reading the provisions that specify the coverage.

And how can candidates face consumer voters on election day if they say, well, we passed a health reform bill, but we really cannot tell you what it will cover? And how can consumers support a bill without knowing its key provisions? It is crucial that Congress spell out the benefits in the bill.

Fifth, comprehensive benefits will be meaningless if they are combined with a catastrophic insurance policy. The promise of comprehensive benefits will be a hollow promise if consumers can buy a catastrophic insurance policy with a $2,000 or $3,000 deductible and then be considered "insured."

That kind of deductible does not deliver preventive care to children, does not deliver insulin to diabetics and does not meet many pressing health care needs. What it means is, financial barriers to care for low and middle income families. They would end up with an unfunded medical savings account and a policy with a catastrophic deductible.

Sixth, if guaranteed benefits are not comprehensive, there will be a burgeoning supplemental market. What we think will happen is that the insurance companies that are excluded from participating in health alliances will rush in to find their market niche, the supplemental market.

All of the problems that have plagued the health care market will be shifted to the supplemental market—preexisting conditions inclusions, denied coverage, frivolous variations in policies. Companies will continue to seek enhanced profits by dictating to doctors how they should treat patients and the result will be a multi-tiered health care system. The lucky people who can afford coverage will get it; the unlucky will be relegated to bare bones coverage.

The last point I would make, Mr. Chairman, is that consumers need comprehensive information about health plans and about providers to allow for a fully informed choice and that any bill should build in consumer protection to construct a health care system that is accountable to consumers from the outset and that has a good redress policy if the services that should be delivered are not delivered.

Thank you very much for inviting us here today and for showing an interest in the consumer point of view.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Karpatkin appears in the appendix.]

The CHAIRMAN. Let us see, 1939 was 55 years ago.

Ms. KARPATKIN. Yes.

The CHAIRMAN. So, I mean, you finally got a hearing. It just takes patience. [Laughter.]

Ms. KARPATKIN. Patience and enough subscriptions to keep us in business that long.

The CHAIRMAN. And enough subscriptions. I think Ms. Gleeson's comments about how the protocols developed at Blue Cross and Blue Shield are just published and very much available to anybody, is very much in the spirit of the Consumer Union, which has been there from the beginning.

Ms. KARPATKIN. Yes.

The CHAIRMAN. Dr. McArdle, I think your testimony is prepared with Kenneth Sperling.

Dr. MCARDLE. Yes, Mr. Chairman, and Ken is behind me to join us in the question and answer if you like.

The CHAIRMAN. We welcome you, Mr. Sperling, particularly for including a glossary. This is a very helpful thing. Sir?

STATEMENT OF FRANK B. McARDLE, PH.D., MANAGER, WASHINGTON RESEARCH OFFICE, HEWITT ASSOCIATES LLC, WASHINGTON, DC, ACCOMPANIED BY KENNETH L. SPERLING

Dr. MCARDLE. Thank you very much, Mr. Chairman, Senator Chafee, Senator Durenberger. I come back to the committee flooded with memories. It was a little over 10 years ago that I sat, and it was then on that side, behind Senator Heinz, hoping I would have the answers to all the many questions that he would always have; and I miss him this morning as I am sure you do.

The CHAIRMAN. We do.

Senator CHAFEE. Well, we all do. We certainly do. Very much.

Dr. MCARDLE. He would have been a leader on this issue.

Now we are in the business of benefit design and we have been in this business, my firm, for about 50 years. So as you are about to become benefit designers, what we thought we would do is share with you what we go through at the micro level, hoping there are some lessons therein for you.

The first observation actually may surprise you quite a bit, which is even though we consider ourselves to be expert benefit designers, we do not make the kinds of decisions that Senator Danforth is talking about today. It is the company, the employee/employer community that we are working with that will make those decisions.

They do that taking into account employee preferences, the competitive position of the company, the human resource objectives, and the business objectives of the company. Indeed, we work with some large companies—Ken does—headquartered in New York, for example, who will be so large that they do not even think corporate headquarters should have one company-wide package. Instead, they will delegate those decisions to their different business units.

The second point I would like to make is that plan design is not static. It changes just about every year. It is not a question of getting the benefit design right and then just fixing it. What you have

to do is, go through a process of a good design strategy which will then test the ongoing effectiveness of what you have done in prior years.

The CHAIRMAN. That is because medicine is changing.

Dr. MCARDLE. Exactly.

The CHAIRMAN. That is why Blue Cross and Blue Shield has to think about investigational modes because they are coming along at every hour, which is the heroic age of medicine that we are in, which is wonderful.

Dr. MCARDLE. Exactly. And in terms of plan design we could have designed something a few years ago which would have been state-of-the-art and today would be less than optimal, because the market has changed in the meantime.

What drives best practice in this design is data, data, data, data. Fortunately, we are now able to generate more data and better data than we were in the 1980's. So there are ways of looking at things like medical necessity and provider efficiency with much more care.

The fourth observation is, if you were to take a snapshot of all the different plans in this country today, what you would find are plans at different levels of sophistication. There are going to be small employers who are pretty much handicapped and would have to buy what is the insurer's product, off the shelf. Then you would find larger employers who are doing most of the right things. And then a small group of innovator companies who have the economic risk and the ability to initiate change. And it does not take long before the innovators' example spreads throughout the national plan design. But it takes time for that to happen.

The CHAIRMAN. It sounds like something you could say about corporations with respect to financing and product development.

Dr. MCARDLE. Correct, but it has a practical implication for you though, which is, as you get data, the innovator companies are the tip of the ice berg. But the data you are getting from national sources is the ice berg.

The CHAIRMAN. Very good. Did you hear that, John?

Dr. MCARDLE. The historical bulk is not necessarily the most innovative thing.

The CHAIRMAN. The median practice is not what you really want to look for here.

Dr. MCARDLE. Exactly. And that is what it is easy to do using historically generated data.

The fifth point is that effective plan design depends not only on the design, but on the related skills of managing change. Most of the employers we work with already have health benefits, so it is not a question of designing a first, new plan for them; it is a question of changing an existing design.

So there is a whole expertise that has developed on how you change plans in a way that minimizes disruption, because the employers that we work with will do a double back flip to minimize disruption because it is not productive, it creates negative employee relations, et cetera, and I can describe some of the things that they do to avoid disruption.

Our sixth point is that we are on the edges of some major, major new changes in plan design, and these have to do with data analy-

sis and some projects, for example that Ken was involved in, where we can now track provider efficiency using the total episode of care. We are just beginning to be able to do this, but it is a breakthrough kind of development.

The seventh observation is that you can agonize over any single plan design, but no one plan design is going to fit all the situations and serve them equally well. It is not just a clinical decision of what is comprehensive; it is a question of who is deciding what is comprehensive and whether you consider unnecessary care "comprehensive" or adequate care "comprehensive."

Our eighth observation is that flexibility really characterizes the current state of plan design in America today. We have given you data. There is lots of choice among plans and among medical providers, and you need to distinguish those two concepts because it is possible to have a narrow choice of plan and a big choice of providers. And the employees put more emphasis on the choice of medical providers than the choice of medical plans.

Senator CHAFEE. Could you just repeat that again, please, what you are saying there.

Dr. MCARDLE. Sure.

Senator CHAFEE. I understand the difference in choosing providers, but you were saying what about the choice in plans?

Dr. MCARDLE. Probably the most common question we get asked is: How much choice is there in the marketplace today? When I try to answer it, I say, "You have to distinguish between choice of plans and choice of providers."

If you look at just choice of plans, about 9 out of 10 companies offer 2 or more plans; about half of them offer 3, 4 or 5 plans. So there is a lot of choice of plans. But the plan may not necessarily allow you to choose your own medical provider.

When you look at what employees are motivated to buy, they look first of all at choosing their own doctor. So I could design, and not me, anyone could design, one single plan that has more choice of providers than two other plans.

The CHAIRMAN. Just for our lexicon purposes, plan is the benefits package.

Dr. MCARDLE. Well, it is the benefits package, plus the cost sharing features that go with it. Yes, Senator.

This choice is the way of balancing some of the diverse needs that you have been talking about earlier today. How do you decide what you put in the package? Well, if you keep the moving parts simple and you give employees true choice, they can make educated choices. In fact, they learn more about health care in that process.

And our last observation would echo what you heard from OTA, at least in their written statement, which is, that there is a lot of work involved here. And it is not just a question for the Finance Committee of deciding what goes in the initial package, but as your witness from Oregon addressed, what happens every other year?

You know how much time you spend on the budget. It is conceivable you would be spending a lot of your valuable legislative time on yearly plan design changes.

Mr. Chairman, that concludes my remarks and we would be happy to answer any questions.

[The prepared statement of Dr. McArdle appears in the appendix.]

The CHAIRMAN. Thank you very much. We will get back to you.

Now the last word, and not inappropriately at all, is Dr. Straub, who is the Senior Health Policy Analyst of the Jackson Hole Group, and somehow manages to combine that with living in Connecticut, which speaks flexibility and good sense. Good morning, Doctor.

Dr. STRAUB. A recent change. Thank you.

STATEMENT OF WILLIAM H. STRAUB, M.D., SENIOR HEALTH POLICY ANALYST, JACKSON HOLE GROUP, WESTPORT, CT, ACCOMPANIED BY HELEN BOWMAN, HEALTH POLICY LIAISON, JACKSON HOLE GROUP

Dr. STRAUB. Mr. Chairman and members of the committee, I would like to thank you on behalf of the Jackson Hole Group for the opportunity to present their views on standard benefits. I have been asked really to focus my remarks on two issues.

First, why we need a standard benefit plan; and second——

The CHAIRMAN. So you start there.

Dr. STRAUB. We start there. Why? And then second, who should determine what specific benefits are included or excluded in the plan—what you have been really talking about most of the morning.

In addition to my oral testimony this morning, I would like to submit for the record a draft discussion paper which we have developed——

The CHAIRMAN. On designing the initial uniform effective health benefit plan.

Dr. STRAUB. Right.

The CHAIRMAN. It is placed in the record.

Dr. STRAUB. It addresses design issues and also offers two model benefit plans for consideration.

The CHAIRMAN. We will put that in the record.

[The paper appears in the appendix.]

Dr. STRAUB. Thank you.

As regards to the need for standardized benefits, simply put a standardized benefit plan is fundamental to creating a simple and seamless health care system for our country, which seems a proper goal for meaningful health care reform.

More specifically, a standard benefit plan would be important for the following reason. First, and foremost, as noted by Senator Durenberger, standardization of benefits would facilitate the side-by-side comparison of accountable health plans based on price and quality.

Standardization of the cost sharing associated with the benefit plan would also be important in this regard. The combination of community rating, standard benefit plan and standardized cost sharing are really necessary conditions for competition to occur on a level playing field, which is really the very basis of the notion of managed competition.

The CHAIRMAN. Will you say that once again? A standard benefit package——

Dr. STRAUB. Standardization of the cost sharing——

The CHAIRMAN. And the cost sharing which you give as a model benefit.

Dr. STRAUB. Along with community rating really creates an environment——

The CHAIRMAN. That is another triad we have here today.

Dr. STRAUB.—really creates an environment in which competition can occur fairly.

Now I had a litany really of other things that relate to why you want a standard benefit plan, but frankly I think Senator Durenberger summarized those very nicely in three of his points and they were touched on by other people this morning. So I am going to bypass those and really jump to something which has not been considered much, but again Senator Durenberger touched on his relation or his testimony to an article in the New England Journal of Medicine.

The point is that I think it is very dangerous to look at the standard benefit plan in isolation. It really has to be looked at in the context of the delivery system, which is highly variable across the United States. So if you take a comprehensive benefit plan and take it to his State in Minneapolis, you could probably have that benefit plan provided to patients for 30 percent or less than you could in other regions of the country.

The reason is that managed care is highly developed in like the City of Minneapolis and there is currently intense competition.

I come from Pittsburgh, Pennsylvania originally. The penetration of managed care in Pittsburgh is about 10 percent, not very competitive. So if we took that same comprehensive benefit plan to Pittsburgh I would estimate it would cost 30 percent more. So I think it is important as you look as a Finance Committee in trying to determine the cost of a standard benefit package that you look at it in the context of the delivery system. I am thankful for the editors of the New England Journal for supporting that simple notion.

Examples of standard benefit plans are around today. You can go to Cal PERS and you will find one. In Minneapolis they exist. And several of the States which have health care plan initiatives also are using or embracing the notion of a standard benefit plan.

I would like to now jump to who should really develop the benefit plan. We feel that as a matter of principle the standard benefit plan should be based on scientific documentation of efficacy and relative cost effectiveness. That sounds nice, but as Dr. Herdman really testified earlier, we do not have much information on that yet.

But we are trying to get it. And each issue of a medical journal that you pick up today will have more and more studies that are beginning to answer those kinds of questions. So I would agree that we do not have the information that we need today, but it is coming. I think if you look down the road 5 to 10 years you will see the ability to be able to make more and more rational decisions about what should be included or not on a scientific basis.

For this reason we have advocated that a National Health Board or Commission, appointed by the President and approved by Congress, be charged with developing and modifying the benefit plan.

Congress could then vote up or down the benefit plan or any subsequent modification.

While opposed to politically defining the benefit plan at the Federal level, we are equally opposed to leaving it to the States or individual health plans for many of the reasons I would have cited earlier that a really speak to the need for standardization.

I think in the final analysis—and this was also alluded to before, but I think is an important point—is that public acceptance of health care reform proposals could depend on the public's perception of the benefits that are offered and the cost to individuals in terms of premiums they will have to pay and the cost sharing that is associated with the benefit plan or potential tax increases they may have to bear.

In this regard, it is very tempting to define a benefit plan in initial legislation instead of deferring to some yet undefined or ill-defined national commission. An alternative at this point might be to identify simply a model or proposed plan in the initial legislation that could be subsequently modified by a commission once it is established and then approved by Congress prior to implementation.

But I think it is a difficult issue. It is important that people have something to look at and see what they are getting. But I think it is also dangerous, frankly, despite the respect I have for you gentlemen to be involved in the actual design of the benefit plan. I will stop at that point.

The CHAIRMAN. That is very generous of you. There is no harm in certain candor. What qualifications would anyone on this committee, with say the exception of two or three persons, have to make judgments of these kinds? I mean, which of us is a medical doctor? Which of us is a nurse? Which is a CPA?

This has been fascinating and the name that keeps coming up is Senator Durenberger, Senator Chafee. So, Senator Durenberger, you are first.

Senator DURENBERGER. Thank you, Mr. Chairman. I will try to be brief out of respect to everyone.

The CHAIRMAN. No, take your time.

Senator DURENBERGER. Earlier there was this discussion of whether a plan is a benefit package or not. I had to smile because we are sort of living in the heyday of employee benefits, because in a dysfunctional market when employers want to change that market so that they can get prices down and employees smarter, they hire folks like Hewitt and lots of others.

As long as they are working to change that market, there are tremendous opportunities out there. I would just say from my relationship with these people, thank God they have been there in this marketplace because all of you have made tremendous contributions to the power that employers have in changing local markets by changing the way people buy their health care.

But again, just to try to add maybe a conceptual dimension to what we are talking about, the health plans that we have experienced in Minnesota are not benefit packages. There is a benefit package in the design and there is some standardization that we try to work at, particularly through employer groups like the Health Care Action Group. That is largely for comparability reasons.

But the plan that we are talking about, Mr. Chairman, if you talk about health insurance as we have known it, the benefit package is the plan. There is no question about it, because you then look to see what is covered, what is not covered, and then we have these endless debates about, you know, who is in and who is out and the chiropractors, etcetera.

But the accountable health plan that the President has recommended and that we have all recommended is something different. It is an entity which has had a lot or a little discussion here until Tuesday I think at that hearing.

But that entity really is what is going to change this market for us. In an accountable health plan, I will just give you one illustration, Mr. Chairman, in our community and I may ask Dr. Straub a question about standardization. There is no one description of the design of each of these health plans. They will look organizationally somewhat different. They might be a Kaiser-like organization where, you know, the entity owns the hospitals and they pay salaries to the doctors.

It might be a Mayo Clinic such as was described here. It might be a hospital dominated system like Gordon Sprenger was talking about, making relationships with health plans and doctors. It can be a variety of things. What it has in common is the linkage of the insurance function, the administrative or management function, an investment in new technology and change function, and then the clinical services function.

I have been anxious to read just part of a description of services that are provided by one of our accountable health plans in Minneapolis and this is a full-page newspaper ad that came out from Health Partners this week. It is an open letter to members of Health Partners.

It says there are 4-year objectives for the 600,000 plus members of Health Partners are to reduce by 25 percent the number of heart disease events; increased from 75 to 95 percent the number of children in our system who are fully immunized; improve the early detection of breast cancer reduced by these specific figures—50 percent the cases of breast cancer that reach an advanced stage before being detected; increased early detection of adult onset diabetes; reduce by 25 percent the progression from high risk state to——

None of this is remedial. All of this is preventive. And you are not going to find the set of services they are going to use to get there in any benefit plan. But they have the incentive in this health plan to keep people healthy.

The CHAIRMAN. That has that pattern we have been talking about as sort of the paradigm shift in economics and education from input to output.

Senator DURENBERGER. Yes.

The CHAIRMAN. How you get to a 25 percent reduction in adult diabetes is one thing, but we are getting there.

Senator DURENBERGER. That is right. We are going to describe our relationship in terms of the results that it produces for every year—healthier people who also share in the cost savings that comes to everybody in the plan from these healthier practices.

That is just to make it clear, I think, what we are talking about here when we describe a basic benefit package. It is not synony-

mous with an accountable health plan and yet it is the national rules by which we hope that each of these health plans has to play. But then exactly what they do, community by community, is going to differ.

The CHAIRMAN. Let us put that in the record.

Senator DURENBERGER. Yes, I would be pleased to do that, Mr. Chairman.

[The open letter submitted by Senator Durenberger appears in the appendix.]

Senator DURENBERGER. Thank you.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. I was interested in looking at Mr. McArdle's statement of Hewitt Associates. If you look at the bottom of his statement you will see the different cities that Hewitt is in, some 60 cities across the world. It is rather astonishing.

It brings home once again, Mr. Chairman, the fact that——

The CHAIRMAN. The Wellington, the Wiesbaden, The Woodlands, Zurich.

Senator CHAFEE. Yes. There are some I do not know where the cities are. I do not know where Rowayton is.

Dr. MCARDLE. That is in Connecticut, Senator.

Senator CHAFEE. Well, I ought to know where that is.

The CHAIRMAN. Some distant State.

Senator CHAFEE. But I did with interest note that Hewitt is in five cities in Australia, for example.

The CHAIRMAN. Yes, Adelaide, Brisbane——

Senator CHAFEE. Brisbane, Melbourne, Perth and Sidney. The point is, Mr. Chairman, that we are exporting our talents and skills. In other words, it is an industry that the United States is particularly adept at, and it all counts in the balance of trade, shipping skills and abilities.

Dr. Straub, first I want to thank the Jackson Hole Group. In your Jackson Hole Number II you came out in support of the voluntary alliances, something that I feel strongly about.

The CHAIRMAN. Is Jackson Hole II published now?

Dr. STRAUB. I have seen a draft of it. It is available.

The CHAIRMAN. You have an aide trying to help you.

Dr. STRAUB. Yes. The question is is it available for distribution?

Ms. BOWMAN. The early draft is available, but under major revision right now. The provisions are based on what Dr. Ellwood talked about on Tuesday.

The CHAIRMAN. We can expect them in the next week?

Ms. BOWMAN. We could get you a copy of the original paper that was at discussion last week, but a lot of the provisions have been changed.

The CHAIRMAN. Fine. Do that, will you not?

Ms. BOWMAN. It is due out March 16.

The CHAIRMAN. Good.

Senator CHAFEE. Further, I think the point that they stress here, Mr. Chairman, is very important; that you touched on yourself, and that is that the benefits is a moving target. You cannot set in con-

crete what the benefits are going to be, because of the rapid changes in technology and medicine that are occurring.

That is why we, in our plan, have provided that the commission can come to Congress every year with changes to a benefits package. And again, we have that provision as I mentioned to Dr. Feder, that we then have an up or down vote, so that Congress cannot log roll with it. If you vote no, then it goes back to the Benefits Commission for further consideration.

Now, Dr. Straub, as I gather you gave that some up checks; you approved of that.

Dr. STRAUB. I approve of the general notion of having a commission doing it. We would support that. But again, I would go back to the point you are at initially where you are trying to get public acceptance of something and perhaps the need to be a little specific in order to gain that public acceptance of the plan.

I think it is going to be hard to sell the public on something that is vague or out there in the future. So you have to have I think some kind of model of what you are beginning to talk about.

Unfortunately, it is a little bit like a wonderful book by a guy by the name of Joseph Heller that came out I think back in the 1950's called "Catch 22." And basically, "Catch 22" says you cannot do this without having that. But it also says you cannot have that without doing this.

So it becomes sort of a vicious circle. I think that is where you are at with this issue.

The CHAIRMAN. Now, let us be clear. Catch 22 was you cannot get out of Italy unless you can show that you are mentally disturbed.

Dr. STRAUB. Correct.

The CHAIRMAN. And if you want to get out of Italy in the war time that is a sign of sanity. [Laughter.]

And so you never get out of Italy.

Dr. STRAUB. Exactly. Which relates to this.

Senator CHAFEE. Yes. I would point out, however, that Mrs. Karpatkin is not quite accurate in the statement that you have in your testimony on the bottom of page 3 and the top of page 4 where you say "other bills include broadly defined benefit packages that do not even include prescription drugs" and you refer to our package.

That is not quite accurate because if you look in our bill, it says the covered items, starting on page 89, the covered items of services includes prescription drugs. Now you can say that on page 89 it says subject to procedures for clarification and modification and so forth, and then we list prescription drugs.

So I suppose you can say there is a capability of the commission to knock it out. We would not expect that to be true because we have specifically delineated it. And furthermore, under our plan it comes to Congress, and if they do not like it, then they can, of course, reject it and demand that the benefit package come back with prescription drugs.

I do not want to beat that to death. But I do want to point out that prescription drugs is, indeed, an important part of our uniform benefit package.

The question I have, if I might, Mr. Chairman.

The CHAIRMAN. Take your time.

Senator CHAFEE. I have trouble understanding what Mrs. Gleeson is referring to, and what the others seem to have touched on specifically, on page 2 of your testimony, where you say it is all right to have multiple standardized benefit packages. But we do not want a proliferation of widely varying benefit packages.

Now what is the difference? What is the difference between multiple standardized benefit packages and a proliferation of widely varying benefit packages?

Ms. GLEESON. The issue that we are trying to draw attention to here is we are unsure that one standardized benefit package will meet all the needs. We think you might need incremental, yet standardized packages. You need maybe perhaps one level for the smaller employers and a higher level to accommodate the expectation of the larger employers.

Why we do not think there should be a wide variance in these particular packages is because that will lead to adverse selection. What you would like to do is just have some incremental differences and the issue is totally affordability.

I think at the lowest level we have a responsibility to make sure that a basic benefit is affordable and it does not impose a financial hardship on those who are the lowest wage earners.

Senator CHAFEE. But any time you get a variation in a package—we discussed this with the previous panel—it seems to me you get adverse selection; i.e., you can have a basic benefit package and it will be less expensive. So is that not the package that healthy young males that do not ride motorcycles will head for?

Ms. GLEESON. Well, I think there are things that would also go along with that. Yes, if you are healthy and you do not think you have a lot of risks you are going to go for the basic benefit package. That is why we are talking about small increments.

Obviously, if the variation gets very large you are precipitating the issue of adverse selection. But we do think it is possible perhaps to structure a model of small increments—like Medigap standardization—just to address the affordability issue.

Senator CHAFEE. What do you say to that, Dr. McArdle?

Dr. MCARDLE. Actually, my colleague, Ken Sperling, works on this issue on a daily basis. So he has some real practical observations for you.

The CHAIRMAN. Mr. Sperling, good morning.

Mr. SPERLING. Thank you. Senator, I guess what we would say is based on our experience. Whenever you have a choice of plans and there is the possibility of adverse selection occurring, there is also the same possibility of the opposite happening, which is positive selection.

So that where a plan with catastrophic or low levels of coverage might encourage the healthy people to take it, and the plan with rich benefits might encourage the unhealthy people to take it, those two effects can be netted out and essentially as long as you are looking at both plans in aggregate, the adverse selection can be anticipated, can be priced and can be managed. We have seen that with a lot of the employers that we work with in offering multiple plans to their employees, and employees like the flexibility.

Senator CHAFEE. I just do not understand—it can be priced and it can be managed. Could you explain that a little bit more, please?

Mr. SPERLING. Sure. Maybe I could use a simple example. If we have a plan that might cost $100 if everyone was in it, and another plan that might cost $50 if everyone was in it, and we offered those two plans side-by-side, well the rich plan might attract the unhealthier people and that plan might actually—when all is said and done—cost more than $100. We would expect that to happen.

But the basic plan, the less expensive plan, that attracts the healthy people—when all is said and done—is going to cost less than $50. So we have on one hand, unhealthy people driving claims high in one plan; on the other we have healthy people that are controlling costs in the other plan. And they can be netted out.

Senator CHAFEE. I understand that, if one company has both of the groups. But you have the plan that you are selling for $50 and you are making money on it and along comes a rival company and says, well, I will offer it for $40. So you are out from that; your company Hewitt, I know you are consultants, but whatever company you are dealing with; is out and they are stuck with the other $100 plan that is, indeed costing a lot more than that.

I have great trouble seeing how you can have variations in the plans if you are not going to have cost shifting. That is the question I asked the previous panel. I really do.

The CHAIRMAN. Ms. Karpatkin, you nodded.

Senator CHAFEE. Ms. Gleeson am I off base? Are you not going to have adverse selection with varying plans?

Ms. GLEESON. Well, I think that going back to what Senator Durenberger talked about, and that is what are we expecting now from our health care plan. If we construct some different benefit packages and we assume that some will attract high risk enrollees, one would hope that what is in place with the accountable health plan is some kind of a management system, a medical management system, to better manage the health care expenses and the risk.

For example, if you have high risk people that are smoking you might want to immediately implement smoking cessation programs and so forth. So I think if you are attracting high risk to a certain type of benefit, then the accountable health plan has to be prepared to manage that benefit.

Senator CHAFEE. Ms. Karpatkin, please.

The CHAIRMAN. Ms. Karpatkin.

Ms. KARPATKIN. Yes, thank you. Well, I think there are two major concerns. I agree with you that if we had an inadequate plan that one outcome would be considerable cost shifting and all of the problems that that has caused in the marketplace today will simply continue under the new system. The other also of great concern is that if there is a tremendous variation in benefits, if there is a variation in benefits and a variation in the cost of benefits, the poor people are going to be compelled to choose the lesser coverage, the lesser benefits, the worst plan.

And all of the hopes we have for improving the overall system would be dashed because we would have as my written testimony said, we would have people opting for coverage that really does not do them any good in meeting their health care needs until a catas-

trophe befalls them and then the costs have escalated and it is too late.

The CHAIRMAN. Dr. Sipes-Metzler, you seem to want to say something there.

Dr. SIPES-METZLER. Well, from Oregon's experience, we have been offering a guaranteed benefits package which requires the insurance companies to accept anyone that applies for the package, which is what guaranteed issue means. The rest of the plans for our small business market are medically underwritten which means that they are health screened prior to accepting clients. What we have found is that because of the mandate of having a voluntary guaranteed issue component within that small market package, other packages are more available from insurance companies who know that they are going to have to take the risk one way or the other. They would rather identify the risk up front, learn to manage it and offer a different varying cost structure, if you will, or cost sharing approach to it than to take the risk on blind, which one would almost argue would occur with a catastrophic coverage.

So, therefore, they have been willing to work within the market and with the various employers to provide adequate coverage opportunities for their clients.

Senator CHAFEE. Could I just ask one final question of Dr. Straub?

The CHAIRMAN. Please do.

Senator CHAFEE. You advocate standard cost shifting as I understand it.

The CHAIRMAN. Not standard cost shifting.

Senator CHAFEE. Standard cost sharing.

The CHAIRMAN. You have to get that lexicon word.

Senator CHAFEE. There were three points you ticked off—a standard benefit package, standard cost sharing and standard community rating or community rating.

Now, would you allow variations between different categories of plans? In other words, would it be a standard cost sharing for an HMO as it was for a fee-for-service plan or would it be—were you saying a standard cost sharing for all fee-for-service plans?

Dr. STRAUB. I think that is a very important issue, just because what we are really advocating is standardized cost sharing across all plans. So that an accountable health plan, which has a fee-for-service base or an accountable health plan which has an HMO base, if you will, for example, a staff model, are all competing to deliver the same product.

If you are allowed to vary the cost sharing it is just another way of sort of shifting cost if you will.

The CHAIRMAN. Yes.

Dr. STRAUB. It is shifting cost to the individual. The other thing it does, it really does not have these accountable health plans competing on the same basis. A fee-for-service plan is really competing with sort of an edge because its premium may be close to the same as say the HMO plan, but out-of-pocket expenses to the individual is coming in as higher.

So the plans are really not competing on a level playing field for the same purpose.

Senator CHAFEE. So what you would say is that with the uniform benefit package, within that uniform benefit package you must have the same cost sharing features. In other words, if it is $100 deductible, whatever it is, and a $10 co-payment——

Dr. STRAUB. Correct.

Senator CHAFEE.—that applies right across the board. So then the plans are competing on the basis—the accountable health plans are competing on the basis of quality and price.

Dr. STRAUB. Precisely.

Senator CHAFEE. Because presumably the fee-for-service plan will be more expensive than the HMO.

Dr. STRAUB. Precisely.

Senator CHAFEE. But within the HMO if, let us say, there is a standard deductible of $300, how do you get a deductible with an HMO?

Dr. STRAUB. Well, the HMOs have begun to explore the use of co-payments and deductibles.

Senator CHAFEE. I can understand a co-payment.

Dr. STRAUB. All right.

Senator CHAFEE. But, in other words, you go in an HMO and with a co-payment you have to pay $10. I can see that. But how do you work a deductible with an HMO?

Dr. STRAUB. It is really, I think, just another means of shifting or cost sharing if you will. I mean, how do you work it?

Senator CHAFEE. Yes. In other words, an HMO by definition is a capitated program. So you have paid $200 and somebody has paid $200 for you to belong to this thing. Now what happens? You go there. I got up and I broke my leg. So I go to the HMO.

Dr. STRAUB. It stretches the definition of an HMO. There is no question about it and it puts it more in the realm of a continuum of these care processes or plans which would be more in the PPO type range where you have now a select network. But you are at more risk because it, in fact, is not totally prepaid care.

Senator CHAFEE. So I have to pay something or other in addition to the co-payment, my $10. I have to pay extra, whatever. Let us say that the deductible is $500. I have to work my way up to the $500 before I can go with no charge.

Dr. STRAUB. Precisely.

Senator CHAFEE. What do you say to that, Dr. McArdle?

Dr. MCARDLE. I would just like to add one caution, which is, as I mentioned in my summary, there is so much variety in the system right now that almost anywhere you draw the line it is going to leave a lot of people with better benefits and a lot of people with lower benefits.

The CHAIRMAN. Oh, yes.

Dr. MCARDLE. We put an attachment to our testimony that breaks it out by the States represented by the Finance Committee, and you will see a lot of variation there, even in the deductible.

Senator CHAFEE. Thank you, Mr. Chairman.

And again Dr. McArdle, in pursuing your duties, if you get a chance to go to Sidney, Australia, grab it.

Dr. MCARDLE. I will, Senator. Thank you.

The CHAIRMAN. And thank you all. I think we should not conclude this morning without wishing Senator Chafee and his col-

leagues a very successful meeting in Annapolis where you are going to be dealing with this subject and with the benefit of this advice I cannot but doubt you will return with the answer.

Senator CHAFEE. Well, Mr. Chairman, I want to take this opportunity to say publicly how much we appreciate the thoughtfulness that you have given to this whole effort here, the patience you have shown with those of us who ask questions and the time you have given us. You have been an ideal Chairman. We praise you for the conduct of these hearings.

The CHAIRMAN. You are very generous.

Senator CHAFEE. We could not ask for anything more.

The CHAIRMAN. And with that, we stand in adjournment.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

[Submitted by Senator Durenberger]

HealthPartners

An Open Letter to Members of HealthPartners, Group Health, MedCenters and Choice Plus

Dear Members:

We are announcing an exciting new program to improve your health—**Partners For Better Health.** Our goals over the next four years are to:

1. **Reduce by 25%** the number of heart disease events (e.g., heart attacks) among members.
2. **Increase from 75% to 95%** the number of children in our system who are fully immunized for childhood diseases by age two.
3. Improve the early detection of breast cancer among our members. **Reduce by 50%** the cases of breast cancer that reach an advanced stage before being detected.
4. Increase early detection of adult onset diabetes by screening 50% of high-risk members. **Reduce by 25%** the progression from a high-risk state to active diabetes. **Reduce by 30%** the onset and progression of eye, kidney and nerve damage resulting from diabetes.
5. **Reduce by 30%** infant and maternal complications among our members.
6. **Reduce by 50%** new dental cavities in all age groups for our dental members.

These goals are ambitious and challenge all of us to think about health promotion in new and different ways. If we are successful, the results could change the way the health care delivery system in this country works—for the better.

What we are proposing is a real health partnership with each member of our plans.

This new program—**Partners For Better Health**—will only succeed with your full cooperation and support. You are the key partner. We need your help. We can't do it without you.

We need your help in several ways. First, we will be doing surveys of all members to help us identify which members have a high risk of each of the diseases we are targeting. We will ask questions like—"Has anyone in your immediate family been diagnosed as having breast cancer? If so, who? What is their relationship to you and how old were they when they developed the condition?"

We need you to answer these questions and others like them in order to help us develop the care plans that will achieve these results and improve your health. Your cooperation in completing these surveys and returning them to us will be a key to the success of the program.

We will also need your cooperation and partnership in implementing follow-up actions, treatments and preventive behaviors that will help bring down the risks of the diseases noted. We will provide the best medical care and we may recommend stress reduction courses, changes in eating habits and/or physical activity programs. In each case, we will develop a care plan tailored to your specific needs and we will help facilitate your ability to follow through!

The challenge for all of us will be to work together as true partners to create the health outcomes we all want. You need to tell us what works and what doesn't. You need to give us ideas that we can use to improve our program and provide us with feedback about the ideas we already have. Watch for details about the **Partners For Better Health** program in upcoming issues of your member publications *HealthPartners Today* and *Discover*. Detailed plans and schedules also will be available at our clinics. In the meantime, please join us in this revolutionary new program by calling 883-6723 for more information.

Together we can make a real difference that improves the quality of our health care, as well as the quality of our lives. We ask for your support, your involvement and your commitment. As your health plan, we pledge the same in return.

James L. Evans
Chairperson, HealthPartners

Toni Seppala
Chairperson, Group Health

William Schoenwetter, M.D.
Chairperson, MedCenters Health Plan

George Isham, M.D.
Medical Director, HealthPartners

Paul J. Brast, M.D.
Medical Director, Group Health

Maureen Reed, M.D.
Medical Director, MedCenters Health Plan

PREPARED STATEMENT OF JUDITH FEDER

Mr. Chairman and Members of the Committee: I am, pleased to come before you today to talk about the comprehensive benefit package under the Health Security Act. The Act represents the President's commitment to the American people for health security through a guaranteed comprehensive benefit package.

I do not need to remind you that 58 million Americans are uninsured for some time each year and that millions more have health insurance that does not meet their needs:

- 81 million Americans with pre-existing conditions; people who are paying more or can't get insurance at all or they can't even change their jobs because they or someone in their family has one of those pre-existing conditions.
- Sixty nine percent of policies don't cover pre-existing conditions;
- Less than 40% of privately insured individuals have coverage for routine preventive services, and even in HMO's where preventive care is almost universally covered, more than 50% impose cost sharing on these services.

THE HEALTH SECURITY ACT: COMPREHENSIVE BENEFITS DEFINED IN STATUTE

Mr. Chairman, we all agree that the nation must address these inadequacies in our current insurance system. I am pleased to come before you today to talk about how the President's plan provides services and benefits that will enable all Americans to stay healthy, prevent disease, and do this at an affordable cost. The Health Security Act guarantees all Americans will have coverage for a comprehensive set of benefits defined in statute. We consider it essential to the ultimate success of health care reform to not only **define** the benefit package in statute, but also to assure that the package is **comprehensive.**

Defining the benefit package in statute eliminates the confusion that exists today and prevents patients from discovering, just as they need coverage the most, that they have reached their lifetime limit or that a particular illness or condition is not covered. Just as important, it is impossible to estimate the costs of the benefit package to employers, individuals and the government without clearly defined benefits or cost sharing.

In addition to being clearly defined, the benefit package must be **comprehensive** to avoid the perpetuation of uncompensated care and the cost shifting that exists today. Comprehensive coverage also encourages the use of cost-effective preventive care, instead of the present system, which encourages individuals to wait until their illnesses are severe and costly before seeking treatment.

Second, without a standard comprehensive package, plans may offer benefits designed to attract healthy customers, perpetuating their ability to compete based on adverse selection of "cherry picking," rather than forcing them to compete by providing high quality health care at an affordable price.

Finally, we must ensure access to comprehensive benefits to avoid the creation of a two-tiered system where the wealthy may be able to afford a good benefit package, while the middle class and poor may be forced to purchase only catastrophic coverage with high out-of-pocket expenditures. Certainly those with the means to do so will always be able to purchase "deluxe" coverage—for private hospital rooms, plastic surgery, and other benefits beyond the guaranteed package. Health Security, however, requires that everyone has coverage for medically necessary and appropriate care.

RANGE OF BENEFITS

The Health Security Act provides a benefits package which defines a broad range of health services, prohibits plans from excluding anyone due to pre-existing conditions, and has no lifetime limit on the benefits. The Act does not specify classes of **providers,** rather it provides coverage for a range of **services.**

Services covered include hospital services and services of health professionals. Health professional services are defined to include those services that are lawfully provided by a physician, or those services which could be performed by a physician and which are provided by another person who is legally authorized to provide those services in the state.

Other services covered include emergency services; clinical preventive services; mental illness and substance abuse services; family planning and pregnancy related services; hospice care; home health care; extended care; outpatient laboratory services; outpatient prescription drugs; outpatient rehabilitation services; durable medical equipment; vision care including routine eye examinations, diagnosis and treatment for defects in vision and eyeglasses and contact lenses for children under age 18; dental care; and health education classes.

This range of benefits is not, however a "cadillac" package. It is comparable to the average coverage enjoyed by individuals with employment based private health insurance. As noted by the Congressional Budget Office, certain benefits are more generous, such as the coverage of clinical preventive services, while others may be less so.

COST SHARING

It is important to note that the comprehensive benefits package provides cost sharing options for consumers which are standardized to ensure simplicity in choosing among health plans. These options serve to protect consumers from the devastating costs of catastrophic illnesses through limits on out-of-pocket expenditures. They also promote personal responsibility and the appropriate use of health services through copayments and co-insurance requirements for all individuals. Low income individuals will be eligible for assistance with these cost sharing requirements, but they are not waived.

CLINICAL PREVENTIVE SERVICES

Prevention is the cornerstone of the Health Security Act. The comprehensive benefits package includes a wide array of preventive services not covered by the majority of today's insurance plans—immunizations, well-child care, mammography, pap smears and other screenings and early detection measures—which will prevent health problems or help resolve them before they become serious illnesses.

- The plan offers periodic clinician visits—for children, adolescents, and adults—which provide occasions for preventive monitoring and counseling appropriate to each person's age, gender and developmental circumstances. These preventive services will be fully covered with no cost sharing.
- Our first investment in healthy children is good prenatal care for mothers. To remove any financial barriers to these critical services, the Health Security Act provides for complete prenatal care with no cost-sharing.
- Children will receive a full range of prevention services, including immunizations, well-baby checkups with no cost sharing to ensure that all children get off to a healthy start.
- For women, the Act will cover a schedule of preventive screenings, tests and checkups with no cost-sharing. Certain preventive services will be targeted to groups that have a high risk for particular diseases.
- All women receive clinician visits, including clinical breast exams, at regular intervals with no cost-sharing. All women will also receive routine screening mammograms every two years, beginning at age 50, with no cost sharing.
- Additionally, women of any age can receive clinical services, including clinical breast exams, and mammograms at any time when they are medically necessary of appropriate with cost sharing as specified by their plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

For the first time, all persons with mental and substance abuse disorders, and their families, will have access to specialized services. The proposal gives health plans the flexibility to provide appropriate types, mix, and level of services for each individual.

The substance abuse and mental illness benefits will provide important services for persons with these disorders. The Health Security Act represents a meaningful improvement over today's typical insurance policy that covers only a narrow range of services, and that encourages expensive inpatient care over more cost-effective alternatives.

The beginning benefit covers services that are important both to reforming the system and to caring for Americans with mental or substance abuse disorders. Distinctly different from typical insurance policies of today, the Act does not limit intensive treatment to inpatient coverage in hospitals but broadens it to residential settings and intensive nonresidential care, such as partial hospitalization and intensive day treatment programs.

Also important in this mix is that the Act includes coverage for diagnosis, medication management, crisis services, and somatic treatment services comparable to that of other health services. Health plans will also have the flexibility to use case management services.

The beginning benefit adopts a flexible benefit design. Under the Act's flexible benefit structure health plans are encouraged to move to a managed benefit. Benefits such as intensive nonresidential services (e.g., partial hospitalization and intensive day programs), outpatient psychotherapy, and substance abuse counseling are

available as substitution for the more expensive inpatient and residential settings. This new structuring is consistent with the mental health and substance abuse benefit in the year 2001, which will rely on health plan management of the benefit rather than on specific limits.

The President is committed to making mental health and substance abuse services an integral part of a national system of health care. The benefit proposed in the Health Security Act is a dramatic step toward eliminating the historic discrimination against those suffering from mental illness and substance abuse.

PROTECTING LOW-INCOME CHILDREN

Under the Health Security Act, low-income families will be members of the same health plans with the same health card as other families in their area, and health plans will receive the same premium payment regardless of the income status of the family. Families who today receive health care through Medicaid will join the alliance and receive assistance in paying premiums to ensure that their insurance is affordable. Eligible low-income families will also receive assistance with cost-sharing.

Every American, including those who are so poor that they currently qualify for health coverage under Medicaid, will be able to receive the federally guaranteed benefit package. However, we recognize that some children who are covered under Medicaid currently receive some services that go beyond the new array of benefits. In an effort to ensure that there is no gap in service for low-income children, the plan includes a new, capped, federal program for poor children with special needs.

This supplemental program will have federal eligibility criteria, roughly structured on current Medicaid criteria, and it will cover a federally determined set of services for eligible children under age 19. Basically, the services will include Medicaid services that are not included in the comprehensive benefit package, such as hearing aids, transportation, and some therapies.

PROTECTING INDIVIDUALS WITH DISABILITIES

Comprehensive coverage of preventive care and medical treatment goes a long way toward easing the threat of disease that faces all children and families in America. But families who have relatives with chronic health problems or severe disabilities face special challenges.

Outlawing pre-existing condition exclusions and removing lifetime limits on benefits will help these families enormously. But many of them need more—they need long-term supports to help them keep their loved-ones at home, in the family, in the community. Families are not looking to be replaced by a service system—but they need some reinforcement. They need a real choice beyond institutionalizing their relative or bankrupting the whole family to keep their children at home. The plan offers real hope, in the form of a major new expansion in community-based long-term care.

The new long-term care program, which represents a significant increase in spending for community-based long-term care, will provide a range of community supports to people with severe disabilities, regardless of their age or income. This new program will be financed jointly by states and the federal government. However, it will differ from Medicaid in that federal match rates will be higher, federal funding will be capped, people will not have to be poor to qualify, and the program will be highly flexible.

In addition, the Medicaid long-term care program will continue to cover both institutional services, including nursing homes and ICFS/MR; and community-based services, including personal care, home health, and Medicaid home and community-based waivers.

OTHER INVESTMENTS

The President recognizes that insurance alone can not meet the needs of all Americans. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act includes several new investment proposals.

First, the Act includes two new grant programs to support school health education programs and to fund school health services. Under the Act, $50 million in FY 1995 will be authorized to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

In addition, the Act authorizes $100 million in FY 1996 rising to $400 million per year by 1999, to help fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illness and injuries and referral

and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

In addition, new funding will be authorized to help support public health initiatives of special importance to the health of children including immunizations, lead poisoning screenings, health education and violence prevention.

Finally, the Health Security Act invests in primary care and enabling services such as transportation and outreach services and in the training of primary care doctors including pediatricians, obstetricians and family physicians to ensure that children and expectant mothers will not lack appropriate medical care.

CONCLUSION

Mr. Chairman, the Health Security Act was designed to guarantee all persons legally residing in the United States access to comprehensive medical care. The President has taken a bold step in spelling out that guarantee by defining a standard package of benefits in legislation. This package is balanced to provide access to the full range of medically necessary or appropriate services while ensuring affordability through the appropriate use of cost sharing and the emphasis on acute and post acute services. This guaranteed benefit package is essential to the success of health care reform in terms of improved health for all Americans at a cost this Nation can afford.

PREPARED STATEMENT OF SUSAN GLEESON

Mr. Chairman, and members of the committee, I am Susan Gleeson, Executive Director for Medical and Quality Management, of the Blue Cross and Blue Shield Association, the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for about 67 million people. I appreciate the opportunity to testify before you on issues in health care reform related to benefit design, including issues related to new technology and experimental treatment. Benefit design is a central element in health care reforms that are designed to bring greater accountability to the insurance markets. The Blue Cross and Blue Shield System strongly supports these reforms.

BLUE CROSS AND BLUE SHIELD SUPPORTS INSURANCE REFORM

Insurance reform is the foundation for comprehensive federal health care reform. Private insurers, employers, health care providers, and consumers are already changing the way we do business to address the needs of a changing market. States are moving ahead with reform efforts of their own. It is time for the federal government to join these efforts to build a health care system for the twenty-first century. Federal health care reform can support the transformation of the nation's health care system by establishing a high, uniform standard of accountability for all health plans. Delaying federal reform could needlessly dampen the pace of change in the private sector. Strong federal action will maintain the pace of reform.

We believe that the best, most effective strategy to contain costs while still meeting the needs of patients and consumers is the enactment of reforms that will permit true price competition—for the first time—in the financing and delivery of health care in this country. Price competition—not health alliances, not price controls—will result in lower costs and better quality.

The adoption of strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market—and assuring fairness to consumers. We have described the essential elements of insurance reform in previous statements to this Committee. Today, we will focus on one area of standards—those related to design of the benefit package.

THE ROLE OF BENEFIT DESIGN IN HEALTH REFORM

Standardization of benefit designs is one of the important elements of insurance reform. The Blue Cross and Blue Shield Association supports standardizing the benefit packages to be offered by Accountable Health Plans (AHPs). We are not sure that it is possible to design a single benefit package that meets the diverse health care needs and financial resources of individuals, small employers and large employers. It may be that health plans should be allowed (or required) to offer multiple, but still standardized benefit packages each of which includes a basic level of guaranteed coverage. This is similar to the approach used to standardize supplemental offerings to the Medicare population (i.e., Medigap coverage) which has been successful. The proliferation of widely varying benefit packages has had a destructive

effect on consumers, providers, and health plans. Standardization of benefit packages offers advantages to all three.

- For consumers, standardized benefit packages will make it easier to compare products based on their premiums and indicators of quality and subscriber satisfaction. Consumers will no longer have to struggle to figure out the 'value' of a large number of diverse benefit designs, or anticipate the impact on their anticipated out-of-pocket costs of widely differing cost-sharing requirements. And they will not have to worry about the 'fine print' that may make coverage offered by apparently similar health plans, in reality, quite different. Such standardization is part of making coverage more secure.
- For providers, standardization of benefit designs will contribute to lower administrative costs through the adoption of streamlined administrative procedures, uniform forms, and electronic data interchange.
- For health plans, standardization of benefit designs will contribute to lower administrative costs and reduce the use of benefit design to compete based on risk selection. By reducing 'competition' from health plans offering inadequate benefits, it will also reward those health plans that have continued to offer comprehensive benefits, but learned to effectively manage utilization and costs.

The requirement that all Accountable Health Plans offer one or more of the standardized benefit packages is an essential element of insurance reform. In designing the standardized packages, several considerations should be borne in mind:

1. The benefit packages should be 'affordable'—that is have an expected premium that will not cause a significant financial hardship for either small employers or low wage workers. Benefit design largely determines how expensive coverage will be for both employees and employers. It also determines the 'value' of coverage to individuals and families. Concern for providing coverage of a broad range of services must be balanced against the need to keep coverage affordable.

2. Standardized benefit designs should allow health plans to create realistic incentives for consumers to use providers that are part of a health plan's provider network. Increasingly, cost-effective health insurance products rely on a selected network of providers to manage care. Providers have widely-varying practice styles and costs. The careful selection of providers can produce substantial savings for subscribers. Differences in cost sharing are used to encourage subscribers to use providers that are part of the health plan's provider network. These differences between in-network and out-of-network benefit levels need to be meaningful. Sizable differences in benefits can be allowed without creating a financial barrier to access as consumers can always limit out-of-pocket costs by using a health plan's provider network.

3. Differences in benefit design across the standardized packages should not be so great as to cause a major problem of risk selection or segmentation. Benefit design strongly influences the extent of risk selection or segmentation. Generally, benefit packages with very narrow benefits and substantial cost-sharing will be more attractive to healthy individuals and families who do not expect to use medical services. Comprehensive benefits with limited cost sharing are more attractive to individuals and families in poor health who do expect to use substantial amounts of medical care.

4. The standardized benefit package may need to rely on limits on the amount or duration of coverage to limit spending for medically inappropriate care. When a benefit package includes unlimited coverage of services that lack clear criteria defining 'medically appropriate' care, it will be difficult to manage the cost of coverage. Often benefit designs control the cost of these services by placing limits on the amount of care that will be covered, e.g., offering coverage only for a defined number of visits or number of days of care.

5. Health plans should to continue to have primary responsibility for determinations related to medical necessity. Federal guidelines can be helpful in the development and implementation of policies by health plans to limit coverage of unnecessary or inappropriate care for specific medical conditions for which there are no demonstrated, effective treatments. The nature of this problem, specifically as it arises in the context of experimental treatment, is discussed in the next section.

MEDICAL NECESSITY AND INVESTIGATIONAL TREATMENT

A benefit package defines both the scope of covered services and required cost sharing. These are only part of the story, however. Most benefit designs, including those proposed in the Health Security Act and other major reform proposals limit coverage to 'medically appropriate' medical care. The identification of medically nec-

essary care has been the focus of intensive efforts over the past twenty-plus years. These efforts have taught us three things:

1. A significant amount of medical care has little or no benefit for patients and is not needed.
2. Identifying medically necessary care is more difficult than might be expected, requires considerable judgment, and often requires flexibility to meet the needs of different patients.
3. The rapid pace of technological advance requires the constant updating of guidelines for the determination of medical necessity.

Several health care reform proposals raise two issues in the area of medical necessity. The first involves the categorical definition of medical necessity that would result in the coverage of many services that are not now defined as medically necessary and that would fail to meet reasonable criteria of necessity. The second involves the requirement that health plans pay for the 'routine' costs associated with investigational treatment. We believe that neither of these policies are appropriate as both would unduly limit the ability of health plans to appropriately manage costs.

- Some proposals categorically classify certain-groups of drugs and devices as non-investigational and safe and effective, without requiring any data to demonstrate their safety or effectiveness. This restricts the ability of health plans to limit the use of untested and unproven technologies.
- The coverage of investigational procedures in approved clinical trials has a laudable objective. But the list of what constitutes an approved clinical trial is overly broad.

Criteria and formal processes for determining medical necessity and non-instigational status have evolved over several years. The current consensus is that these determinations need to be based on scientific evidence. The health care reform proposals that identify categories of drugs and devices as non-investigational clearly undermine an evidence-based process of evaluation and would encourage coverage of untested and unproven technologies.

The Blue Cross and Blue Shield Association's Technology Evaluation (TEC) Program has been a pioneer in the use of on scientific evidence to form conclusions about the effectiveness of new medical technologies. It is one of the nation's leading technology evaluation efforts, having conducted more than 200 assessments since its creation in 1984. The program examines and synthesizes scientific evidence to determine the safety and efficacy of new medical technologies, and does not rely on community practice standards or consensus.

The assessments developed by the program are scientific opinions meant to provide information to those who deliver and manage medical care.

In September of last year, the TEC program expanded to other payers with the collaboration of Kaiser Permanente. David Eddy, M.D., Ph.D., senior advisor for health policy and management for Kaiser concurrently assumed the role of the program's Chief Scientific Advisor. The Medical Advisory Panel, which is the program's external review team, was expanded to include prestigious experts in scientific methods, clinical research, and medical practice. A majority of the panel's members are not independent medical experts with no affiliation with health care payers. Assessments will now be available to other interested parties on a subscription basis.

The TEC Program uses five criteria to determine whether the technology in question improves health outcomes such as length of life, ability to function, or quality of life. Cost is not a consideration in technology evaluation. The five TEC criteria are:

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

Many BCBSA Plans will consider only technologies that meet all five TEC criteria to be eligible for coverage. These Plans find new medical technologies that do not meet all the criteria to be investigational.

Health care reform offers an opportunity to reshape certain aspects of our health care system. But lowering the threshold and standards for determining what is non-investigational or medically necessary would increase costs without a commensurate increase in value to consumers.

Most health care reform proposals call for insurers to extend coverage for patient care costs of certain treatment available through approved clinical trials. While we support the concept of greater funding for clinical research, we are concerned that current proposals are overly broad and would lead to costly funding of research that may not be either a high priority or definitive. We believe that insurer support of clinical trials should be targeted to well designed, high priority trials that address questions important to society.

The Blue Cross and Blue Shield system's Demonstration Project on Breast Cancer Treatment offers a good illustration of the issues posed by experimental treatment and an instructive model for how health plan's might support technology evaluation under reform. High dose chemotherapy with autologous bone marrow transplant support (HDC/ABMT) for breast cancer and other solid tumors. Clinical studies of HDC/ABMT have not yet established that this treatment is as safe and effective as conventional chemotherapy in the treatment of certain stages of breast cancer. Many BCBS Plans exclude coverage for the treatment because they consider it to be investigational.

HDC/ABMT for breast cancer has been evaluated twice by the Association's Medical Advisory Panel since 1988, most recently in 1991 by David Eddy, MD., Ph.D. It does not meet the five TEC criteria. Until this study was undertaken there were no well-controlled trials. Studies relied on poorly matched samples, and small differences in survival demonstrated between HDC/ABMT and conventional chemotherapy for breast cancer were not statistically significant. Furthermore, treatment-related mortality and morbidity from HDC/ABMT exceeded that from conventional chemotherapy.

Despite the lack of conclusive evidence that HDC/ABMT is as good as, worse, or better than conventional chemotherapy, coverage denials by BCBS Plans and other payers generated unprecedented media interest and litigation. Some researchers advocate the treatment and women have sued, convinced that this treatment is their last hope. A recent California jury award of 69 million dollars to a breast cancer patient denied coverage for his treatment has increased the controversy and worried payers who are attempting to limit coverage to scientifically established technologies. Some subscribers want access to this service regardless of the lack of scientific evidence supporting efficacy. Unfortunately, as a recent editorial in the *Journal of the National Cancer Institute* stated, some members of the oncology community "have raised the public's expectation far above what is supported by the published data. We have no evidence as of yet that any patient will be cured by this therapy who would not have been cured by more conventional treatment" (Henderson, 1991).

The Demonstration Project on Breast Cancer Treatment is an innovative effort to help resolve the clinical controversy surrounding the efficacy of HDC/ABMT for breast cancer. The Demonstration Project is an attempt to return the debate to the appropriate forum of clinical research and away from the courtroom and television. Only well-designed research can answer the question "does HDC/ABMT work for breast cancer?"

The purpose of the Demonstration Project is to support randomized controlled clinical trials comparing the efficacy of HDC/ABMT with that of conventional chemotherapy in the treatment of advanced breast cancer and early breast cancer with a poor prognosis. The clinical trials are being sponsored by the National Cancer Institute (NCI), the Clinical Trials Cooperative Groups, and the Philadelphia Bone Marrow Transplant Groups. Increased BCBS Plan financial support for this costly investigational treatment will speed accruals to the trials and help answer clinical controversy.

The Demonstration Project provides financial support, on behalf of BCBS subscribers, to institutions that are participating in the trials and have entered into contracts with the BCBSA. The all-inclusive financial support payments are separate and distinct from coverage. They constitute support for clinical research and not benefit payments. The financial support payments defray a significant portion of the patient care costs of HDC/ABMT, including inpatient, physician, and ancillary services. Participating institutions are expected to share in the costs of treatment as well.

Currently 17 Plans and the Federal Employee Program, accounting for 40 percent of our membership, are participating in the Demonstration Project. To date, 43 hospitals are participating and eligible hospitals are welcome to enter into contracts at any time. Several of the supported trials are accruing very well and we believe our support contributes to the rapid accrual.

BCBS Plans and the Office of Personnel Management for the Federal Employee Health Benefit Plans have been willing to invest resources in the Demonstration Project to obtain the clinical data necessary for determining the efficacy of this toxic

and costly treatment. In the absence of such financial support, the trials might not be conducted or completed. These well-designed, large, randomized multicenter trials will provide the data essential for assessing this technology.

The TEC program and the HDC/ABMT demonstration project both illustrate how the public and private sector efforts can be coordinated to address the problem of defining medically appropriate care. The private sector can benefit from federally sponsored research that provides evidence of efficacy, effectiveness or cost-effectiveness. It can also participate in projects to provide the data needed to make these assessments. However, federal guidelines are also useful in identifying treatments for which evidence of effectiveness is lacking, thus relieving health plans from the responsibility of making these decisions in isolation.

The policy issues presented by benefit design are among the most complex and difficult of any issues in health care reform. There are no easy solutions, and many uncomfortable tradeoffs, for example, between comprehensiveness and affordability of coverage. 'Solutions' to issues such as the definition of medically appropriate care may significantly limit the ability of health plans to manage costs through the elimination of inappropriate or ineffective treatment. These issues require careful analysis and deliberation. We look forward to working with this Committee to address these issues as the debate on reform evolves.

STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman: I want to join in welcoming our distinguished witnesses to the Committee, and I would like to thank them for coming before us today to discuss the very critical issue of health care benefits.

This hearing will provide us with very important information. It addresses the fundamental questions of what sort of benefits will be provided to American citizens under proposed health care reform, who will receive those benefits, and how those decisions will be made.

So far, much of the debate on health care reform has focused on how the different plans will be financed. However, when all is said and done, and a final plan is finally decided upon, what our constituents will want to know is: what is covered under this new plan, and what is not?

That is why it is imperative that the Congress examine this issue very seriously. It is a delicate balance to determine how we can provide all consumers with the best possible health care, while respecting the limitations of available resources, and the needs of providers to have the flexibility to tailor services to medical necessity.

I am very concerned about proposals that suggest that a "one-size-fits-all," standardized benefits package be established. Clearly, just as our nation has a uniquely diverse population, our citizens have unique health care needs. A benefits package that is appropriate for a young, relatively healthy person, for instance, with few health concerns certainly would not be appropriate for an elderly person requiring greater degrees of care, or dependent on prescription drugs. We must recognize that only through the flexible provision of health care options, and not a standardized, predetermined set of benefits, will we be able to offer each person the health care that best suits their individual needs. We cannot shove every American into one health care box.

I must also express my dismay at the proposals that put the decisionmaking power over benefits into the hands of politicians, rather than those who know best—providers and patients themselves. The notion that a national health board, government-appointed experts, or even Congress can best determine which benefits can meet our nation's health care needs is not only misguided, but irresponsible. Surely, it seems quite obvious to me, that those who are trained in providing care are those closest to the patient, and they should be making the recommendations as to which benefits will best serve their needs.

The Consumer Choice Health Security Act of 1993, which I have drafted with Senator Nickles, reflects my belief that we must provide consumers with maximum choice in their health care plan, while allowing them to receive the benefits which best fit their needs. Any plan we approve must include this flexibility.

With that said, I look forward to the testimony of our experts. I thank you all, once again; for coming today, and I thank you for opening this critical dialogue, Mr. Chairman.

PREPARED STATEMENT OF ROGER C. HERDMAN

Mr. Chairman, I am pleased to appear before the committee to testify on issues related to benefit design in health care reform.

The benefit package can be viewed as the centerpiece of health care reform. The American public will, to a large extent, judge the success of health care reform efforts by what services they get from the health care system, in relation to the price they will pay.

Often, patients and providers focus on a specific item in the benefit package—is the service they think they will need or they think they will provide included or not? However, there are key conceptual issues that must be understood before considering the inclusion or exclusion of specific items. I have been asked to provide an overview of these key conceptual issues. My testimony addresses two top priority questions that must be considered before individual diseases or services are considered:

- How does the benefit package relate to other parts of health care reform?
- How will the size, scope, content, and priorities within the benefit package be determined now and in the future?

Mr. Chairman, these are the main points about the selection of benefits based on the work of OTA in this area:

- The "benefit package" (in terms of a list of covered and uncovered services, items, and providers, whether specified by Congress or not) is a critical component of the health reform debate and will affect the services that patients get, and the costs of health reform, and will be a focus of intense deliberations and heavy lobbying by important constituent groups.

However,

- Other aspects of health reform will interact dynamically with the benefit package to affect the services that patients get and the costs of health reform. These include, for example, patient cost-sharing, managed care and utilization controls, caps on expenditures, and provider payment. Thus, should Congress wish to influence the services that patients get under health reform, Congress needs to attend to aspects of health reform other than the benefit package per se.

As a consequence, then,

- Numerous interested individuals and organizations will try to influence the services and providers specifically listed as covered, by targeting this list and the other aspects of health reform.
- In response to all of the above, it would be useful if all decisions about the size, scope, content, and priorities within a benefit package could be made—by Congress or anyone else—on the basis of scientifically validated evidence on the effectiveness and cost-effectiveness of services, and the impact of various financial incentives on health care costs, the delivery of services, and health outcomes—that is, what "works" and the least costly of equally effective alternatives. While there is some information in this area that can be helpful to guide Congress in its deliberations, the usefulness of this approach is limited, and a great deal of judgment will still be required.
- Given that science cannot provide all the answers (although it can point fruitfully in some directions), and that the issues are inherently complicated, Congress should be aware that the design of a benefit package is not likely to be a one-time-only decision. Congressional involvement in benefit design is likely to continue, although the level of Congressional involvement may vary depending on the provisions of reform.

My testimony will draw from work that OTA has completed or has well under way.

WHAT IS A BENEFIT PACKAGE?

Let me first discuss how a benefit package is typically defined, and then how it may be influenced in the context of other reform decisions.

Typical Definitions: A List of Covered Services, Items, Providers, Settings, and Conditions

As depicted in the chart, a benefit package is typically described in health reform proposals in terms of covered services.[1] Covered items, covered providers, covered

[1] The term "services" is difficult to define separately from providers, settings, and items associated with an episode of prevention or care. The dictionary defines service in relation to health

settings, covered conditions, and covered populations may also be specified separately from covered "services." Because these terms are used differently in different reform proposals, a few definitions may be in order.

- **Services** typically refers to:
  - the services provided by broad groupings of health professionals (e.g. physicians' services);
  - specific health specialties (obstetrics and gynecological services; substance abuse or mental health services);
  - specific groupings or categories of procedures (e.g., diagnostic services; preventive services).
- **Items** typically refers to such things as prescription drugs, eyeglasses, hearing aids, prostheses, contraceptive devices, crutches, wheelchairs, oxygen tanks, other durable medical equipment.
- **Providers** refers to such health professionals as physicians, nurse practitioners, psychologists, chiropractors, and a myriad of other health professionals (i.e., not institutions).
- **Settings** refers to the places in which services (and some items) are delivered, and in which health care providers work. Examples of settings are physicians' offices, community health centers, hospital outpatient departments, emergency departments, nursing facilities, long- and short-term hospital inpatient facilities, optometrists' offices, school-based health centers.[2]
- **Conditions** refers to the diseases, disorders, disabilities, and other health problems that patients may have (or be at risk of, if they are not prevented).

As shown in the examples in *Tables 1, 2, and 3,* services, items, providers, settings, and conditions can be defined very broadly, in rather specific detail, or a combination of both. For example, the bill illustrated in Table 1 lists 9 broad categories of covered items and services. Table 2 provides an example of one proposal that is very specific about some of the services to be covered, while at the same time referring quite broadly to other services. All three proposals would make use of a national board or commission that would either clarify or specify particular services eligible for coverage. Table 3 provides an example of a proposal that specifies that a national board specify a" "uniform set of effective benefits," with the additional provisions that:

- such benefits include "the full range of effective clinical preventive services . . . appropriate to age and other risk factors;"
- such benefits shall include a full range of diagnostic services.

An important provision of benefit packages is stated in almost all reform proposals. All covered health care is to be restricted to care that is medically necessary and appropriate (see, e.g., table 3).[3] These terms may or may not be defined; if they are defined, the definitions are generally broad. Thus, of the three benefit proposals illustrated, the benefit proposal illustrated in Table 3 is perhaps most broad about services other than clinical preventive services and, to some extent, diagnostic services.

Some reform proposals do not list any categories of services or providers, leaving the definitions of covered and uncovered medical care to the market, within some broad guidelines (e.g., medical care as defined in the Internal Revenue Code).

At the same time that the list of covered services, items, providers, and settings can be crucial, explicit exclusions from coverage may be just as important in the impact of health reform on what patients get and what reform costs (e.g., see Table 2).

To the extent Congress does not explicitly specify the services, items, providers, settings, and conditions that are covered or uncovered, others will have an opportunity to make those decisions. In addition to the designation of a national board or commission, or regional alliances, with some specific decisionmaking authority, there may be other aspects of reform that can influence who gets to make these decisions and how, and the likely impacts of the decisions on the care that patients

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and medicine as a branch of hospital medical staff devoted to a particular specialty. Health services are no longer associated solely with hospitals. however, and the term has taken on broader meanings. For ease of presentation in this testimony, the term "service" is sometimes used to refer to the combination of services, items, providers, and settings that may be involved in an episode of health care.

[2] Some settings are now referred to as "providers" (e.g., hospitals).

[3] Even the directions to the national commission in the proposal in Table 3 specify that the uniform set of effective benefits shall include such categories of health care services that the Commission determines will provide for the delivery of medically appropriate treatment.

get, in terms of access and quality. The next section of my testimony discusses some of these factors.

OTHER IMPORTANT FACTORS AFFECTING THE CARE THAT PATIENTS GET

As also shown in the **chart**, a reform proposal's list of covered services is only one influence on the care that will be delivered to patients as a result of reform. The list of covered services—whether specified by Congress or an organization authorized by Congress—will be filtered through a variety of other influences that can affect access and quality. These include other reform decisions, and other factors that are less likely to be influenced by reform decisions.

Other Reform Decisions

One important set of factors will be influenced by other reform decisions, particularly on the financial and utilization control aspects of reform and delivery, for example: reform provisions governing patient cost-sharing, caps on expenditures, managed care/utilization controls, and payment to providers.

As noted in Box 1, these types of reform provisions are based largely on the premises that:

1. There is a considerable amount of waste and inappropriate use in the health care system.
2. Inappropriate care can be driven out with the appropriate financial incentives, rules governing utilization, or both.

However, a careful examination of the available evidence suggests that there are reasons to doubt the extent to which large amounts of savings can be found by eliminating waste and inappropriate care (see Box 1). I will have more to say on this topic when I review some of OTA's work on the effectiveness and cost-effectiveness of services.

This is not to say that there are no inefficiencies in the health care system, or that some combination of patient cost-consciousness, expenditure caps on premiums, capitation, and strong utilization controls, could not eventually result in lower overall health expenditures, without harm to patients' access to necessary, high quality care. However, these efforts all rest on the assumptions that:

- someone can determine at relatively fine levels of detail what care is effective and cost-effective, and for whom; and that
- mechanisms are available to bring such information to bear on the delivery of services.

The evidence on these assumptions is weak.

Our ongoing work, Assessing the Assumptions Behind Health Reform Projections, has demonstrated that, as unclear as the interpretations of evidence on the effectiveness of specific technologies may be, there is at least a method and a body of evidence for some technologies that can clearly separate cause from effect with some degree of certainty.

In contrast, changes in financial incentives and other rules governing the delivery of care, are rarely made or studied using an experimental—or any prospective—research design (U.S. Congress, OTA, Oct. 1985; U.S. Congress, OTA, May 1992; U.S. Congress, OTA, Assessing the Assumptions, in preparation).[4] And yet it is possible that these other aspects of reform can—by design or unintentionally—have a substantial impact on the services that patients get, and potentially on their health (e.g., U.S. Congress, OTA, Sep. 1992b, Sep. 1993a). The next section reviews, to the extent possible, the available evidence on the effects on access, costs, and quality.

Patient Cost-Sharing

Patient cost-sharing is the share of providers' charges that insured patients are obligated to pay out-of-pocket when they receive a service (see box 2). Patient cost-sharing requirements are designed, in part, to make people "think twice" before seeking care and to forgo the use of services that are expected to bring little benefit.

Evidence. Unlike in the case of other financial incentives and utilization controls, there is some experimental evidence, albeit limited, on the effects of patient cost-sharing on use of services, associated expenditures, and patients' health (Newhouse, et al., 1993; U.S. Congress, OTA, Sep. 1993a). OTA recently reviewed the experimental and non-experimental evidence related to the effects of patient cost-sharing,

[4] This is not necessarily the fault of researchers. Typically, a number of changes to a system are made simultaneously, and it is difficult, if not impossible, to sort out the "active ingredients" in any changes, if one is observed (see, e.g., U.S. Congress, OTA, Oct. 1985).

Box 1—Waste and Inappropriate Care

Some have argued that we will be able to afford all effective services by systematically eliminating unnecessary and inappropriate care. This argument is based upon estimates that 20 percent or more of health care services and/or expenditures may be unnecessary or inappropriate (Aetna, 1992;[1] Brook, Kamberg, Mayer-Oakes, et al., 1990;[2] Cutler, 1993).

The actual amount of care that is truly without potential benefit is unknown. Available estimates have been derived from studies of services that were widely suspected to be overused, or from studies of variation in health services provision (U.S. Congress, OTA, Prospects for Health Technology Assessment, in preparation). Ratings of appropriateness are often based on judgment and consensus, rather than detailed and unequivocal evidence. Further, services that may be underused have been given less attention; correcting the amount of underuse may offset much of the projected savings from elimination of inappropriate overuse. Finally, estimates of inappropriate utilization do not necessarily translate into estimates of unnecessary spending.

Clinical practice guidelines are one possible way to raise the level of knowledge about what constitutes appropriate care. However, we are still at an early stage in our understanding about how best to produce and promote valid guidelines. And guidelines, of course, can encourage more care, where appropriate, as well as less. Thus, while identifying and eliminating unnecessary and inappropriate care clearly benefits patients and payers alike, we should not, in the near future, be confident that expanded services under health care reform can be funded by savings on inappropriate care.

[1] An insurance company advertisement suggested that "if our scales are right," "health care in America" is $145 billion overweight" in the sense that "about $145 billion" of the "$735 billion" Americans spent for health care in 1991 was for "unneeded tests and treatment alone" (Aetna, advertisement in *Business and Health*, Sep. 1992). $145 billion is equal to almost 20% of $735 billion.

[2] By some methods, if "equivocal" care is combined with "inappropriate" use, 64 percent of some procedures have been determined to be "not justified" (Brook, Kamberg, Mayer-Oakes, et al., 1990). Brook and his colleagues also found that between 30-and 75-percent of a specific procedure (cardiac pacemakers) had been found to be overused.

SOURCE: OTA, 1994.

and found that, due to the inherent limitations of the available evidence, some of the conventional wisdom concerning the effects of patient cost-sharing is not supported—or only partially supported—by the available evidence.

- For example, the conventional wisdom holds that cost-sharing reduces utilization by promoting the use of more cost-effective, appropriate care and by discouraging the use of unnecessary services. In fact, the Rand HIE suggests that cost-sharing is a rather crude instrument for matching health care services with health needs. Coinsurance deterred individuals from seeking all types of care, even potentially effective treatment and appropriate hospitalizations (according to Rand criteria).
- The conventional wisdom also holds that cost-sharing does not pose any health risks. The evidence suggests instead that the jury is out. The HIE health-related findings are inconclusive in many respects. They do suggest, however, that some individuals, especially lower income persons in poor health, may be harmed by cost-sharing.[5]

The Rand HIE did demonstrate, however, that cost-sharing significantly reduced health care spending by or on behalf of those individuals enrolled in the experiment. The experiment did not, however, examine total health spending by patients otherwise enrolled in health care providers' practices (i.e., it did not examine the effect of potential cost-shifting).

[5] Only the Rand HIE examined the health effects of patient cost-sharing. However, the Rand HIE did not examine the health effects of patient cost-sharing in the form of flat copayments to HMOs.

Box 2—Elements of Patient Cost-Sharing[1]

Patient cost-sharing can consist of:

- **an initial deductible,**
- **plus a percentage of the charge for covered service, sometimes referred to as coinsurance;**
- **up to a maximum annual dollar amount.**

Members of health maintenance organizations (and some other forms of managed care plans) are rarely subject to deductibles or coinsurance,[2] but often pay a flat **copayment** for primary care visits and sometimes for hospitalizations.

[1] For these purposes, patient cost-sharing does not include the insurance enrollee's share of the premium costs. Premium costs serve a different purpose than other cost-sharing mechanisms; they do not directly affect how many services are purchased but rather that mount and type of insurance purchased. Nevertheless, there is a relationship between premiums and other forms of cost-sharing. If a purchaser faces a choice between higher premiums with limited cost-sharing and lower premiums with higher cost-sharing, he or she may choose to purchase the less expensive policy with higher deductibles and copayments or coinsurance. Other factors may come into play in this choice, however, and not all the factors in health insurance purchase choice are well understood (Fischhoff, contractor paper for OTA, 1994; U.S. Congress, OTA, ATA, in prep. 1994).

[2] Unless they choose to use the "point of service" option that is becoming more common, even in former group/staff model HMOs.

SOURCE: U.S. Congress, OTA, Sep. 1993b.

Implications. Most health reform proposals provide for some patient cost-sharing.[6] Policymakers who decide to include cost-sharing should not assume that patients will eventually obtain the care that they need, regardless of levels of patient cost-sharing, patient income, and health. In particular, low-income people in poor health may be harmed by cost-sharing.

Unfortunately, available evidence cannot provide precise guidance on how different types and levels of cost-sharing can be used to induce particular levels of utilization, expenditures, or health.[7] Further, should Congress want to protect people of low incomes from adverse consequences of patient cost-sharing, there have been no examinations of how best to do this administratively.[8]

MANAGED CARE/UTILIZATION CONTROLS

Managed care is a generic term referring to a wide range of health care delivery and payment strategies designed to hold down health care expenditures. Managed care plans typically provide "prepaid care, " that is, the plans have a relatively fixed amount to spend ("capitation"). The plans try to hold to this fixed amount through the use of provider incentives to restrain (hopefully unnecessary) utilization or through other explicit controls on utilization. In managed care plans, individuals other than individual providers and patients—with an eye on overall costs—make many of the care-related decisions, and/or provide explicit incentives to providers to make decisions that will reduce utilization.

Formerly considered an "alternative" form of delivery and financing, managed care is in a state of evolution, if not revolution, and the extent and nature of differing arrangements is almost impossible to describe. By some counts and definitions,

[6] Patient cost-sharing levels may be specified in legislation, referred to a national board or commission for determination, left to the decisions of local entities (e.g., States or private insurers), or some combination of the above. Patient cost-sharing provisions are typically included in sections of reform legislation related to benefits or the benefit package; they are discussed separately in my testimony.

[7] The cost-sharing and service price levels of the Rand HIE, which was conducted between 1974 and 1981, cannot be translated into cost-sharing, service price, and consumer income levels of today. One reason is the inherent shortcomings in the construction of the medical consumer price index; another is the structure and terms of the Rand HIE, in which patients were protected from spending more out of pocket than they had spent before enrolling in the experiment.

[8] It may be important to note, for example, that "low income" was not always equivalent to being below the poverty level in the Rand HIE. Different analyses used different definitions. Thus, it is impossible to tell precisely the level of income at which some people's health may be adversely affected.

almost every insurance plan in existence today contains some aspects of managed care (Bailey, 1994; Schwartz and Mendelson, 1994).[9]

Evidence. OTA has reviewed in depth the literature on the cost implications of managed care for a forthcoming publication (U.S. Congress, OTA, Assessing the Assumptions, in preparation), but has not conducted an in-depth review of the access and quality implications of managed care.

OTA finds that most of the credible available evidence stems from work done on staff and group model HMOs, although these are no longer the dominant form of managed care plan.

Although managed care plans in general have been found to have lower utilization per enrollee than fee-for-service plans, utilization differences vary widely in magnitude and by type of utilization [and type of managed care plan?](Miller and Luft, 1994; U.S. Congress, OTA, ATA, in preparation). There is no evidence that managed care plans have lower overall expenditures (as opposed to some evidence of lower premiums paid by employers). In particular, there is no evidence on how expenditures will be affected in managed care plans with a point of service option.[10] A point of service option is required in some plans, and insurers have found that consumers prefer it.

A common perception is that managed care plans are able to keep utilization and costs low because their utilization control arrangements (and provider incentives) enable them to distinguish between unnecessary and necessary care, and to provide only the latter (see Box 2). Current federally-qualified managed care plans are required to provide a more comprehensive set of benefits than is typically required by fee-for-service plans;[11] the fact that some managed care plans have been able to keep recent premium growth at the level of fee-for-service insurance plans—and direct evidence—suggests that use of some services is lower in managed care plans than in fee-for-service plans. But the jury is still out on the true reasons for the lower premiums (relative to the more comprehensive set of covered services) in the current environment, and whether such low relative premiums can be maintained as managed care becomes the dominant form of care and insurers adopt a variety of utilization controls.[12] The only study that has examined inappropriate care in managed care settings suggests that the amount of inappropriate provision of a selected service can be as large there as elsewhere (Bernstein, et al., 1993). There have been no direct comparisons of managed care with indemnity or fee-for-service plans in terms of appropriateness or quality of care. At the same time, however, there is no evidence that patient health has been harmed by enrollment in managed care plans. Studies on this question are very difficult to conduct (see, e.g., U.S. Congress, OTA, June 1986).[13]

Implications. Many proposals would provide incentives to encourage people to enroll in managed care plans. However, Congress has no guarantees that managed care will—or will not—insure that patients can be guaranteed a comprehensive set of benefits, yet receive only that subset that is appropriate and necessary. Nor is there compelling evidence that overall national health expenditures will—or will not—decline with continued widespread enrollment in managed care plans, although expenditures may decline for some payers.

Caps on Expenditures

Many proposals that list a comprehensive set of covered services deal with the likely increase in associated expenditures[14] by specifying a cap on expenditures, either for governmental or selected private spending. Other proposals would expand government subsidies on the basis of demonstrated savings at a specified level. One proposal provides for cutbacks in the list of covered services and items if spending reaches a certain level (S. 1770—check). No country or program in the United States

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[9] These counts apparently use a very broad definition of managed care (e.g., to include plans with only pre-hospitalization admission certification).

[10] A point of service option gives individuals the choice of going "out of plan" provided that the patient pays a higher level of cost-sharing (e.g., a deductible and coinsurance). Current plans vary in the level of coinsurance they require under the point-of-service option.

[11] As noted elsewhere, fee-for-service plans are required by Federal law to offer any particular set of benefits.

[12] Reasons might include: adverse selection and rationing by inconvenience.

[13] In response to increasing demands for information on quality, the HMO industry is developing a quality of care battery designed for use in quality "report cards." The industry has been unable to find a health outcome measure suitable for use in quality reporting.

[14] All other things being equal, the more comprehensive the specified list of covered services, the higher we can expect the Nation's health care bill to be.

has put such as stringent a cap on expenditures as some proposals aim to do (U.S. Congress, Assessing the Assumptions, in preparation).

As noted in the recent CBO reports on the American Health Security Act (U.S. Congress, CBO, Dec. 1993a, Dec. 1993c) and the Health Security Act (U.S. Congress, CBO, Feb. 1994), a system with expenditure caps or target, and a very comprehensive list of benefits, will put intense pressures on responsible parties to exceed any specified caps.

The intention under the Health Security Act (and other acts with expenditure caps and comprehensive lists of benefits) is to have the caps provide an incentive for third party payers and providers together to drive out-purportedly huge quantities of unnecessary care and other waste in the system (e.g., Cutler, presentation before the Council on Competitiveness, Jan. 1994). However, as noted above, there is as yet no persuasive evidence that such caps will—or won't—act in this way (see Box 1).

Provider Payment Schedules

One apparently obvious means of controlling growth in health expenditures is to control payments to health care providers.

Evidence. Numerous studies have been devoted to attempting to determine how providers might respond to constraints on their fees. Evidence that providers appear to respond by increasing volume has resulted in some policy changes (e.g., the Medicare volume-performance standards). However, it is difficult to tell whether increasing expenditures in the face of provider payment reductions is the result of increases and improvements in technology or whether providers have increased volume independent of technological changes. No study has examined the impact of provider payment changes on health expenditures controlling (or technological change (U.S. Congress, OTA, ATA, in preparation).

Evidence from Medicare's PPS system is sometimes cited as evidence that fee controls can restrain health care cost increases. Inferences are limited because Medicare's PPS system was not studied on a controlled basis. There is evidence that limits in Medicare expenditures for inpatient hospital care have been countered by evidence of large growths in hospital outpatient expenditures, and cost-shifting to other sectors (U.S. Congress, OTA, Assessing the Assumptions, in preparation).

Evidence related to the Medicaid program suggests that there may be a limit below which provider fee caps should not go, if full access is to be maintained. Substantial proportions of providers have cited low Medicaid reimbursement rates as one of the reasons for not participating in the Medicaid program (see U.S. Congress, OTA, June 1991; U.S. Congress, OTA, May 1992). On the other hand, there is anecdotal evidence that other providers may provide potentially unnecessary care in high volumes. Many States are now looking to managed care as a means of controlling growth in Medicare expenditures.

The U.S. has had only short-lived experience with universal provider fee constraints (see U.S. Congress, OTA, Assessing the Assumptions, in preparation).

Implications. It is unclear that reform provisions relative to provider fees would be able—or unable—to restrain the growth in health expenditures. Most—but not all—reform proposals avoid the direct regulation of provider fees,[15] trusting instead to the provisions discussed earlier (patient cost-sharing, managed care, expenditure caps) to reduce utilization. One proposal requires that fees be set in fee-for-service plans.

Other Factors Influencing Access, Costs, and Quality

Another important set of factors affecting the care patients get may be less likely to be influenced directly by reform. These factors include the availability of particular services to patients,[16] and the individual patient and provider characteristics that influence whether people get access to specific types of care (e.g., patients' income and beliefs about insurance and professional health services; providers' beliefs about the needs of particular patients [see U.S. Congress, OTA, September 1992]). I will not discuss these issues further in my testimony.

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[15] H.R. 200 is an exception, in which Medicare would be expanded to uninsured people, and Medicare rates would be applied.

[16] Some proposals have substantial provisions intended to make services more available to patients. However, there is no proposal that has anything equivalent to the required placement of specific services in relation to specific patient needs (e.g., reflecting the prevalence of particular conditions in geographic areas); thus, there is likely to continue to be some problems with the availability of services for some people.

INTERESTED ACTORS

Given the range of influences on what patients can potentially receive under health reform (see chart), and the costs potentially associated with additional services provided, it will come as no surprise to you that a variety of parties are intensely interested in Congress's decisions about the list of covered services and items and the other aspects of health reform. Some of these people are testifying here today, and others are scheduled to testify or have already testified, so I will be brief about what their potential interests may be.

States

States (e.g., State insurance commissions) have been traditionally active in shaping benefits package, although they have lost a considerable amount of influence in the wake of the Employee Retirement Income and Security Act of 1974 (EAISA).[17] The State role varies under the proposed reforms. For example, under most proposals that would maintain a role for private insurers, States would continue to have responsibility for certifying insurance companies and other "health plans," but some proposals remove States' ability to mandate coverage of certain services, items, providers, and conditions. Other proposals give States a broad role, but make them responsible for financing any coverage above and beyond the Federal ceiling.

The nation's governors have indicated that States would like to maintain a maximum amount of flexibility,[18] but they also support national specification of, and employer-sponsored availability of, "a core benefits package that is comparable to those that are now provided by the most efficient and cost-effective health maintenance organizations" (National Governors Association, 1994).[19] According to the Governors, the cornerstone of this package "must be primary and preventive care." However, apparently as a stopgap on utilization increases, they called for relief from antitrust statutes so that health insurance and care networks (i.e., managed care) could be more easily established.[20]

Employers

Even those employers who do not object to an employer mandate to offer or sponsor coverage, are likely to be interested in not having Congress specify a standard benefit package, especially one that is expansive. Rather, most would likely prefer to maintain their ability to design packages on their own (if they self-insure) or negotiate directly with insurance companies, in order to maintain leverage over costs and efficiency as they perceive it (Knettel, 1994; National Association of Wholesaler-Distributors, 1994).

Insurers

Similarly, insurers are unlikely to be willing to have Congress dictate the terms of insurance packages, unless those terms permit them a substantial degree of latitude in controlling the utilization of the covered lists of services (e.g., being able to contract with "preferred" providers as the insurers define them) (e.g., Schaeffer, 1994). Given recent lawsuits (Hall, 1993), insurers may particularly object to a proposals that simultaneously appear to promise a broad array of services but which give them little leverage in deciding what services are medically necessary and appropriate or investigational, and which make insurers bear the risk of underestimating the costs of the benefit package.

Providers

Health care providers are extremely interested in the outcome of the health reform debate. Their livelihoods and, for many, their sense of professional ethics, are potentially at stake.

It is probably a truism that providers as a group would like to see a broad range of services eligible for services, but they may disagree intensely on the types of services and providers that are eligible for exclusion on the.basis of being less effective or necessary, and/or more costly than apparent alternatives. Like other actors, they would like to maintain flexibility concerning the provision of those services, and the

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[17] ERISA permitted corporations to self-insure, making them exempt from State health insurance regulations such as mandated benefits.

[18] For example, the Governors called on the administration and Congress to modify the ERISA statute to give States the flexibility the need to move ahead on health reform, either by statute or through waiver authority [National Governors' Association, Feb. 1994).

[19] The Governors did not agree on whether employers should be required to pay for any portion of the premium, but they did agree that coverage should be available "to those employees who wish to purchase it" (National Governors' Association, Feb. 1994).

[20] The governors also want legislation (rather than waivers) to allow managed care in the Medicaid program.

fees that they can charge for the services they deliver. Providers may be particularly sanguine about proposals that intend that health care professionals will take over both the care delivery and business sides of health care, enabling them to wrest back care-related decisions from financial professionals. Depending on the incentives available, some providers may not want to see their services transformed into the form of "gatekeeping" that will inhibit patients' use of specialized care. Similarly, they are likely to object to clinical practice guidelines that become more. than guidelines.

Consumers

Consumers, as patients, and as the ultimate payers for health services are intensely interested in the types of care that are actually delivered to them under most proposals, and the costs of that care to them. In brief, consumers as a group would like:

- access to a comprehensive set of services;
- provided with high quality and good access;
- with substantial choice of plans and providers;[21]
- at low cost.

Reform proposals vary in all these respects. For example, consumer/patients may or may not be active in:

- choosing an insurance plan;
- choosing whether or not to purchase coverage;[22]
- choosing specific providers, and, ultimately,
- choosing (or participating in choosing) specific diagnostic and treatment procedures in their time of need.

Some proposals attempt to find ways to give potential purchasers of health insurance greater real choice among plans than many currently have. Many proposals emphasize as well the importance of informed choice among plans, requiring, for example, quality report cards and/or a standard benefit package.[23] Similarly, most proposals attempt to provide at least some patient choice among health care providers.

According to past testimony by the Consumers Union, consumers do not want Congress to "pass the buck" on the specification of the benefit package (Shearer, Feb. 10, 1994) and would prefer, as expected, to have access to a comprehensive set of services.[24]

Consumer expectations may be an area in which Congress has perhaps the most complicated job of education and persuasion.

National Boards and Regional Alliances

There are other actors who can be expected to attempt to influence Congressional decisionmaking on aspects of reform affecting the benefit package. Depending on the specific reform proposal, these may include a national board or commission and regional health alliances. Because these types of entities would be quite new and untried, and their proposed duties and responsibilities are still being refined, I will not attempt to predict what objectives these entities might have in their contacts with Congress.

USES AND LIMITATIONS OF EFFECTIVENESS AND COST-EFFECTIVENESS DATA

Given the variety of factors that might influence costs, access, and quality, Congress would likely find it useful to be able to employ—either directly or indirectly—valid scientific information on the effectiveness and cost-effectiveness of particular services to guide decisions about benefits (U.S. Congress, OTA, May 1992; September 1993a; September 1993b; in preparation). This section reviews briefly some of

[21] However, according to past testimony by Shearer, health reform proposals would be improved by requiring that alliances "limit fee-for-service plans to one in order to achieve administrative cost savings and avoid risk selection problems" (Shearer, Feb. 1994).

[22] Some proposals would require almost all individuals to purchase health insurance coverage (e.g., S. 1757); some have a universal individual mandate with exceptions for religious reasons (S. 1770). Other proposals would more or less automatically cover almost everyone via a tax-based system of financing, although individuals would be required to enroll in the specified State-based (federally approved) system (e.g., S. 491; H.R. 1200).

[23] One of the advantages of standard benefit packages is that they make choice on the basis of price (i.e., premiums, or the individual consumer's share of the premium) more feasible.

[24] These services would include nursing home care, expanded home care, more extensive mental health care, and care for children with congenital problems (Shearer, Feb. 10, 1994).

the key conclusions from a series of reports that looked at the feasibility of taking this approach, including OTA's review of the effort by the State of Oregon.

Promises and Limits of Effectiveness and Cost-Effectiveness Information Generally

OTA has generally found that, while effectiveness and cost-effectiveness information can be extremely useful in the policy process, the determination and uses of effectiveness and/or cost-effectiveness remain difficult for a variety of reasons:[25]

- Solid scientific evidence regarding the effectiveness of many—perhaps most—services is lacking.
- When evidence is available, the processes of integrating and evaluating research, and determining effectiveness, are neither simple nor straightforward.[26]
- The finding of "no evidence" is not always equivalent to finding that a service or intervention is not effective; it can mean only that the appropriate studies have not been conducted.

For example, the recent debate over the proper use of mammography as a breast cancer screening device for women under the age of 50 demonstrates the difficult of restricting benefits to only those clearly proven to be effective. When the National Cancer Institute recently concluded that available studies did not demonstrate conclusively that there was a benefit for this age group, there was a strong negative reaction from several medical associations and women's groups. They believe the service should be a covered benefit. The studies did not prove that the test is useless for individual patients, only that it was not clearly shown to be useful. Nor did the National Cancer Institute make a recommendation about coverage per se. Decisions of this type will clearly rely on value judgments, the pressure of stakeholders, and whatever evidence does exist.

Some reform proposals deal in part with the conundrum presented by "no available evidence" by specifying that "investigational" treatments and procedures shall not be eligible for coverage unless the patient receives such treatments as part of an approved research trial. This type of provision may improve the flow of valid information on future innovations, but it does not address the fact that there remain a large number of interventions that have long been generally accepted by the clinical community, but whose effectiveness has never been tested using valid effectiveness research methods.

- The "effectiveness" and "cost-effectiveness" of a service is a relative judgment: how effective is it, for whom, in what circumstances, compared to what? An intervention that is "cost-effective," in the sense that it is less costly than an alternative, will not necessarily save money.
- Net cost also has limitations as a criterion for coverage. For example, a net cost criterion may result in coverage for services with relatively low effectiveness (per resource consumed), while at the same time an intervention that increases costs but confers substantial health benefits might not be covered.[27] Nevertheless, attempting to limit net costs may be appropriate and necessary, particularly in the face of budget constraints and considering that the net costs associated with particular services may be high.[28]

Finally, whether, how, and by whom consideration of both costs and scientific evidence about effectiveness should enter into decisions about health insurance coverage are contentious issues.

For example, Medicare has decided not to pay for liver transplants in the case of liver cancer. It is not the case that liver transplant is completely ineffective for liver cancer: from 0- to 30-percent of such patients are alive after three years (U.S.

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[25] An ongoing OTA assessment (tentatively titled *Prospects for Health Technology Assessment*) is examining in greater detail the potential uses and limitations of ongoing research on effectiveness; the project will also provide Congress with options for improving the health technology assessment enterprise in the U.S.

[26] It is rare that any single study is dramatic enough to demonstrate conclusively that a procedure or treatment is effective, particularly for the range of conditions and people to which it might be usefully applied. Rather, knowledge about the effectiveness of health interventions typically advances through the replication and integration of results (U.S. Congress, OTA, Sep. 1993a).

[27] For example, a certain intervention may be relatively inexpensive to perform, but may result in few health benefits.

[28] For example, under the National Cholesterol Education Program recommendations, the annual screening costs for adults age 20 and over would be almost $870 million. If the cost of treatment were included, the total expenditures might range from approximately $6 billion to $67 billion, depending on assumptions about the age group treated, the effectiveness of diet in lowering cholesterol, and, when diet fails, the medications used (U.S. Congress, OTA, Sep. 1993a).

Department of Health and Human Services, 1990). HCFA's decision reflects a judgment that such a low rate of survival does not justify public coverage.

Under the terms of the final decision to grant the waiver to the State of Oregon for its Medicaid program, the Oregon health commission was told that, in revising its list of covered services, it could not use improvement in an individual's "functional limitation" as a criterion for judging the medical effectiveness of a service in regard to a condition, because that standard would discriminate in favor of conditions that could improve patients' functioning.

Will a reform proposal be able to include improvement in functional limitation or 5 year-survival from liver cancer in its definitions of medical effectiveness? Whether or not Congress decides to make such decisions, they will be made at some level of the health care system.

Despite all the inherent shortcomings of using effectiveness and cost information to make priorities, good evidence on the effects and costs of care and a public discussion of the issues and tradeoffs may lead to a more informed debate on health care policies—nationally and at the bedside of particular patients. Congress should be aware, however, that it takes time to develop any such information in a form that will stand up to public and professional scrutiny.[29]

However, no one type of information—on needs, the effects of care, or resources and public priorities—is likely to be sufficient for improving policies and decisions in health care. Having evidence of effectiveness at some level does not necessarily mean that Congress must require that insurance plans cover specific services.

The next section of my testimony draws lessons from several of OTA's reviews of the effectiveness and cost-effectiveness of particular services or groups of services.

Specific Examples of Effectiveness and Cost-Effectiveness Analysis of Services

OTA has looked at the evidence on the effectiveness and cost-effectiveness of specific services on the margin. Most recently, it reviewed the available evidence on a broad range of clinical preventive services (U.S. Congress, OTA, September 1993a). Previously, OTA had looked at the effectiveness and cost-effectiveness of specific preventive services that were being considered by Congress for inclusion in the Medicare benefit package (see, e.g., U.S. Congress, OTA, Feb. 1990). OTA also has under way a review of the evidence on mental health and substance abuse services as part of its "benefit design series."

Clinical Preventive Services

Preventive services in general are often portrayed as providing "good investments" and thus are regarded as potentially good candidates for health insurance coverage. In evaluating this perception, OTA found that many clinical preventive services have *not* been evaluated in terms of their effectiveness and cost-effectiveness; therefore, whether they are effective or relatively cost-effective is simply not known.

We also found that some, but not all, clinical preventive services for a symptomatic individuals have been found to be *effective* in reducing, or delaying, the incidence and burden of disease for some patients.

However, very few clinical preventive services have been found to be *cost-saving to society in terms of medical care costs* when provided to individuals at average risk for the condition.

In summary, OTA concluded that there is a considerable amount of effectiveness (and some cost-effectiveness) information that can be used to guide policymakers should they decide to require that insurance cover certain preventive services. Specifically, OTA suggests that, if the decision is made to require coverage for preventive services, and if policymakers aim to either save money or improve the health of the population, or both, policymakers will need to:

- take care to distinguish among the preventive services that they cause or encourage to be supported; and
- consider the patient characteristics, frequency, and fee schedules for such services.

If Congress—or whoever designs the benefit package—does not take such care and take such information into consideration, the Nation (or particular payers) could wind up paying for services that are both costly and potentially ineffective.

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[29] For example, the AHCPR panel guidelines on depression took several years to complete. Furthermore, these guidelines are still controversial for good reason (e.g., there is evidence contrary to a central recommendation of the panel that primary care providers be given increased responsibility to screen for and treat depression.

Treatment Services in General

Decisions about the provision of treatment services of any kind have been held to a different standard of evidence than have decisions about preventive services (U.S. Congress, OTA, Feb. 1990; U.S. congress, OTA, Sep. 1993a).

Preventive services have usually been held to a higher standard, for several reasons. Perhaps most importantly, unlike decisions about provision and coverage of preventive services, decisions about treatment services are made in response to obvious patient needs.

Mental Health and Substance Abuse Treatment Services

Treatment for mental health and substance abuse problems and disorders have traditionally not been given the same latitude as have disorders regarded as "physical" (U.S. Congress, OTA, The Biology, Sep. 1992a; U.S. Congress, OTA, Benefit Design, in preparation). This is one area in which compelling evidence about reatment effectiveness would be useful to Congress in making decisions about coverage. The lack of such information is a contributing factor to the widespread uncertainties about the value of mental health services, and reluctance to broaden coverage for them.

Implications of the *available* research evidence for benefit design can be difficult to draw, for the following reasons:

- The groupings "mental health problems and disorders" and "substance abuse problems and disorders" comprise wide varieties of problems and disorders with different manifestations, likely etiologies, and sensitivities to treatment.
- Similarly, the available treatments for mental health and substance abuse problems and disorders comprise a potentially broad range of interventions and settings.
- As a consequence, there is no one research literature—and no one possible conclusion—on the effectiveness of treatments for "mental health problems and disorders" or "substance abuse problems and disorders."

Published scientifically valid research on effectiveness, with the exception of treatments for depression, and some treatments for other serious disorders (e. g., schizophrenia) is quite sparse.

Nevertheless, the literature, and clinical and personal experience is not so lacking to suggest that mental health and substance abuse services in their entirety go completely covered:

- If all treatments for mental health and substance abuse problems and disorders are excluded from coverage, some people with serious and chronic disorders (e.g., depression, schizophrenia) and others with short-term problems in living (e.g., marital and family problems) will not seek treatment that is actually or potentially effective.
- The treatment effectiveness literature is also not very useful as a means of setting particular limits on the number of hospital days or outpatient visits (for psychotherapy or medical management), or deciding between broad categories of: modalities (e.g., psychotherapy v. medication), settings (e.g., inpatient hospital v. outpatient services in general), or providers (e.g., psychiatrists, psychologists, social workers, nurse-therapists). Nevertheless, if Congress decides to fund one modality, provider, or setting and not another, individuals may be deprived of treatment that is actually or potentially effective or equally effective, but less costly.
- Managed care is sometimes viewed as the means of matching patients to appropriate treatments and reducing unnecessary utilization in the mental health field, but managed mental health has not demonstrated that it saves money for society in general (although it appears to reduce psychotherapy- and inpatient-hospital-related expenditures for some groups of insured people); nor has it demonstrated that it improves the mental health of patients.
- The mental health and substance abuse treatment area is definitely an area in need of additional objective, unbiased, scientifically credible research on treatment effectiveness, and on objective, unbiased, scientifically credible syntheses of that information.[30]

[30] In the meantime, most reform proposals tend to compromise, restricting coverage to individuals with "severe mental illness," placing a series of explicit limits on mental health services (except for psychotropic prescription drugs, which are typically treated separately), or leaving decisions about coverage to national boards or commissions or local decisionmakers.

Lessons from OTA's Evaluation of the Oregon Medicaid Proposal

In 1991 and 1992, the State of Oregon attempted to extract a list of the most important and cost-effective services for the most critical conditions from a comprehensive list of all health services and conditions.[31] Oregon had hoped to be able to refine the list of benefits available to Oregon's Medicaid beneficiaries so that it could expand Medicaid eligibility to many of the State's uninsured people.

A 1992 OTA evaluation of Oregon's Medicaid proposal concluded that Oregon's attempt at this exercise demonstrated that outcomes and cost-effectiveness data, while extremely valuable for certain purposes, are inadequate for use as the building blocks of a ranking system of all services (U.S. Congress, OTA, May 1992). OTA concluded that any comprehensive ranking system, whether attempted by Congress, the Administration, a national or local board, or private health plans, would, like Oregon's, need to rely on judgment- and value-based decisionmaking (U.S. Congress, OTA, May 1992).

CONCLUSIONS AND POLICY IMPLICATIONS FOR CONGRESS

The implications of my testimony for Congressional decisionmaking will depend, of course, on the goals of health reform. Health reform can have many goals, but two major objectives are usually cited:

1. That health reform should reduce the rate of growth in health expenditures
2. That all citizens will be able to have access to the services that will help them become productive, healthy individuals; insurance coverage is intended to facilitate that access.

As you are well aware, these goals may be in direct conflict. We know that, all other things being equal:

- expanded coverage for health services will result in an increase in the use of services (U.S. Congress, OTA, DHIMAD, Sep. 1992; U.S. Congress, OTA, Benefit Design: Patient Cost-Sharing, Sep. 1993; Newhouse, et al., Free for All?, 1993);
- additional use of services will cost more money; and
- someone will pay.

How does Congress design a benefit package—and an overall reform package—that will ensure that people get the services they need, without seeing national health expenditures overtake the nation's gross domestic product? Congress faces decisions about:

- *whether* there should be a standard benefit package as part of reform;
- *how extensive* or narrow in scope that package should be, now and in the future;
- *the intended and unintended consequences of other aspects of reform* on what patients get and how much we as a Nation (and particular entities and individuals) pay for it; and, last but not least,
- *who decides,* now and in the future

(Box 3 notes some specific combinations of these questions as they are reflected in particular reform proposals.)

Congress has not faced health system decisions of this scope and magnitude in a long time. There are few existing working models to confidently build upon.[32]

Some may call some reform proposals' attempt to be very specific—or to have a national board specify covered items and services in detail—an attempt at micromanagement, but the temptation to provide specifics is understandable, given the history of previous expansions of coverage, in particular Medicare (see **Box 4** on Medicare).

Your decisions can have a substantial impact on the health care services people obtain, on the costs of the health care system, and, ultimately, on the health of the Nation. My intention here was not to try to persuade you to go in one direction or another, but merely to lay before you some of the issues you face as you consider the centerpiece of any health reform proposal—the benefit package. Science can provide some guidance, but many of the decisions are political or social. The decision-

[31] Mental health and some other services were not included in this effort.

[32] There is, for example, no national "standard benefit package," except for Medicare and Medicaid and, to some extent, for the Department of Veterans Affairs. There are also few Federal rules that directly govern premium prices, provider payments, utilization controls, patient cost-sharing, or eligibility for insurance coverage, particularly in the private sector (see, e.g., U.S. Congress, OTA, June 1991; U.S. Congress, OTA, Sep. 1992b).

making process will obviously not end with the passage of reform, although future decisions can be shaped by reform.

I may have provided you with more questions than answers, but I'd be happy to try to answer any questions you might have.

Box 3—Benefit Design Questions

- Should Congress specify in detail a comprehensive and detailed list of covered services, while at the same time providing incentives and rules intended to have other aspects of reform result in people getting only those services they benefit from?
- How should Congress decide what is to be in such a comprehensive and detailed list?
- How does Congress decide which incentives will promote the delivery of only those services that are necessary and appropriate and the least costly of the available alternatives?
- Should Congress instead try to take Oregon's Medicaid waiver approach and attempt to specify a list of services prioritized in terms of effectiveness and cost-effectiveness?
- Should Congress leave the specification of a list of covered items and services to a national board?
- Should Congress provide the board or local providers with directives to use information about effectiveness and cost-effectiveness as the basis for decisions?
- How much public input should there be? How shall it be obtained?
- Should Congress specify a list of broadly defined covered services and items and hope to limit utilization solely by providing consumers with greater financial penalties for the use of such benefits (e.g., large copayments and deductibles)?
- Should Congress allow decisions about the scope and depth of benefit packages to be highly variable as they are now, by being primarily in the control of private insurance companies and employers?
- Should each State be permitted to regulate the design of standard benefit package and rules governing access and cost for all residents of its State?
- Should Congress take an incremental approach, requiring coverage for a limited set of services initially, and expanding the benefit package gradually? If so, how should it decide what to add and when?

Finally, health and health care are not static, and during the reform debate, Congress will also need to think about how to modify the benefit package over time. There will always be new and recurring diseases and disorders (e.g., HIV infection and AIDS, multiple-drug-resistent TB [1]), evolving interpretations of disorders as being at least partially within the purview of the health care system (e.g., substance abuse, violence, stress); and new technologies, providers and settings. There is likely to be a continuation of newly developed evidence about the ineffectiveness of certain traditional and unexamined procedures, and evidence about the relative effectiveness and cost-effectiveness of new v. traditional procedures.

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[1] See, e.g., U.S. Congress, OTA, The Continuing Challenge of Tuberculosis, 1993.

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Box 4—Medicare

The Medicare program was passed with a short, but broad list of covered services, to wit, hospital and physician services. Medicare cost escalation occurred even though Congress legislated that the only services covered were to be "medically necessary and appropriate," and that patients contribute toward a premium for outpatient physician services. In 1965, Medicare Part A was projected to cost $7.5 billion in the year 1985. Instead, HCFA estimated in 1992 that 1985 Medicare Part A expenditures were $48.6 billion dollars (U.S. Congress, OTA, Assessing the Assumptions, in preparation).

The discrepancy between the projected costs of the Medicare program and the actual recent costs have been attributed to poor statistical projection methods. However, the broad definitions of covered services, and the incremental expansions over the years, typically for broadly specified populations or services, may be equally to blame. The ESRD program under Medicare is perhaps the most dramatic example that, if a service is written into law, there will be an incentive to get or to provide that service, all other things being equal.[1]

[1]The line between consumer demand and provider-induced demand is not a bright one. A considerable amount of available evidence suggests that while patient-consumers are largely responsible for initiating an episode of diagnosis and treatment, health care providers appear to drive the intensity of the services delivered (and the related expenditures) (U.S. Congress, OTA Benefit Design: Patient Cost-Sharing, Sep. 1993b).

SOURCE: OTA, 1994.

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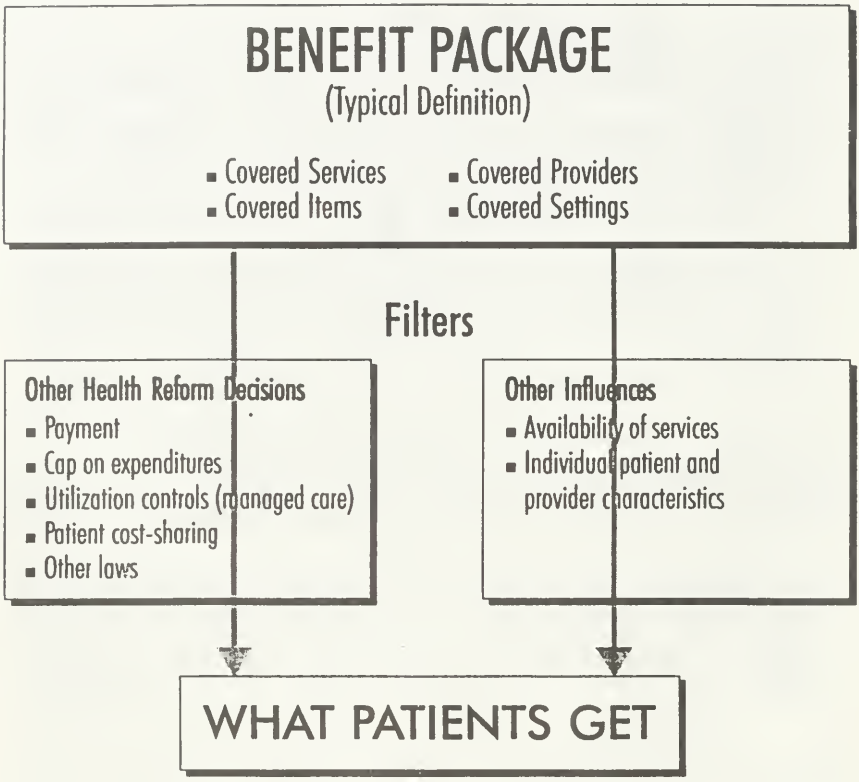
BENEFIT PACKAGE
(Typical Definition)
Covered Services
Covered Items
Covered Providers
Covered Settings
Filters
Other Health Reform Decisions
Payment
Cap on expenditures
Utilization controls (managed care)
Patient cost-sharing
Other laws
Other Influences
Availability of services
Individual patient and provider characteristics
WHAT PATIENTS GET

Table 1--Example of Covered Items and Services, Broadly Defined

Covered Items and Services Specifically Listed
"1) Medical and surgical services (and supplies incident to such services).
"2) Medical equipment.
"3) Prescription drugs and biologicals.
"4) Preventive services.
"5) Rehabilitation and home health services related to an acute care episode.
"6) Services for severe mental illness.
"7) Substance abuse services.
"8) Hospice services.
"9) Emergency transportation and transportation for non-elective medically necessary services in frontier and similar areas."

NOTE: Covered items and services listed are to be "clarified" by a Benefits Commission. The Benefits Commission's clarification would be submitted to Congress in the form of a legislative proposal that would be voted on (or rejected) by Congress. Clarification can include the deletion of covered items and services in categories 1 through 7 only. Clarification cannot include the addition of any benefits. In addition, the Benefits Commission (and, therefore, Congress) is not permitted to specify particular providers who may be authorized to deliver any of the services or items, nor is it permitted to specify any particular procedures, treatments, or classes of procedures or treatments that may be covered.

Table 2--Example of Proposal with a Combination of Broad and Detailed Lists of Items and Services Covered and Excluded from Coverage

Bill Section and Item or Service	Level of Specification
Sec. 1111. Hospital services	Combination: Inpatient hospital services; outpatient hospital services; 24-hour a day hospital emergency services, with "hospital" as defined by the Social Security Act.
Sec. 1112. Services of health professionals	Combination: Inpatient and outpatient health professional services, including consultations, that are provided in...a home, office, or other ambulatory care setting; or...an institutional setting; and services and supplies (including drugs and biologicals which cannot be self-administered) furnished as an incident to such health professional services, of kinds which are commonly furnished in the office of a health professional and are commonly; additional definitions of a health professional, limitations, and exclusions apply[1]
Sec. 1113. Emergency and ambulatory medical and surgical services	Broad
Sec. 1114. Clinical preventive services	Specific, as to procedure, eligible populations, and periodicity
Sec. 1115. Mental illness and substance abuse services	Specific, as to eligible populations, specific interventions, day and visit limits
Sec. 1116. Family planning services and services for pregnant women	Broad
Sec. 1117. Hospice care	Defined in terms of the Social Security Act
Sec. 1118. Home health care	Defined in terms of the Social Security Act, with specific limitations added by S. 1757
Sec. 1119. Extended care services	Defined in terms of the Social Security Act when provided to an inpatient of a skilled nursing facility or a rehabilitation facility, with other specific limitations added by S. 1757 .
Sec. 1120. Ambulance services	Specific definitions in S. 1757
Sec. 1121. Outpatient laboratory, radiology, and diagnostic services	Broadly defined, but eligible population specified (upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility).
....[2]	

Sec. 1141. Exclusions	(1) Custodial care, except in the case of hospice care under section 1117. (2) Surgery and other procedures performed solely for cosmetic purposes and hospital or other services incident thereto, unless-- (A) required to correct a congenital anomaly; or (B) required to restore or correct a part of the body that has been altered as a result of-- (i) accidental injury; (ii) disease; or (iii) surgery that is otherwise covered under this subtitle. (3) Hearing aids. (4) Eyeglasses and contact lenses for individuals at least 18 years of age. (5) In vitro fertilization services. (6) Sex change surgery and related services. (7) Private duty nursing. (8) Personal comfort items, except in the case of hospice care under section 1117. (9) Any dental procedures involving orthodontic care, inlays, gold or platinum fillings, bridges, crowns, pin/post retention, dental implants, surgical periodontal procedures, or the preparation of the mouth for the fitting or continued use of dentures, except as specifically described in section 1126.

Table 3--Example of a Proposal That Defers Most Decisions to a National Board

- The uniform set of benefits submitted [by the Commission] shall include such categories of health care services that the Commission determines will provide for the delivery of medically appropriate treatment by [accountable health plans] AHPs.
- Such benefits include "the full range of effective clinical preventive services appropriate to age and other risk factors".
- Such benefits shall include a full range of diagnostic services

[1] In particular:

The items and services described in this section do not include items or services that are described in any other section of this part. An item or service that is described in section 1114 but is not provided consistent with a periodicity schedule for such item or service specified in such section or under section 1153 may be covered under this section if the item or service otherwise meets the requirements of this section.

[2] Sections 1122 through 1140 are not included in this table

PREPARED STATEMENT OF RHODA H. KARPATKIN

Thank you for inviting Consumers Union [1] to testify today on the issue of comprehensive benefits in national health reform legislation. This Committee will play a pivotal role in shaping health reform legislation. The bi-partisan leadership of Members of this Committee—with intensive work on the part of Senators Pryor, Daschle, Riegle, and Durenberger—was successful in enactment of consumer-friendly reforms of the Medicare supplement insurance market in 1990. The medigap reform serves as an inspiring model for how the Congress can and should work to achieve health care reform.

Like many Members of this Committee, Consumers Union's efforts in support of health reform go back many years. In 1939, *Consumer Reports* noted that forty million Americans received inadequate medical care and called for enactment of the Wagner National Health Bill, which would have been a "cornerstone for a national health program." [2] In 1946, *Consumer Reports* supported the Wagner-Murray-Dingell Bill, which would have established federal compulsory health insurance.[3] In 1975, *Consumer Reports* published a comprehensive comparison of five proposals for national health insurance and established five goals that a national health insurance plan must meet to serve the consumer interest. We published a two-part series, "The Crisis in Health Insurance" in 1990, and a three-part series in 1993 that reviewed wasted health care dollars, consumer satisfaction with Health Maintenance Organizations, and solutions to the health care crisis.

In 1939—over fifty years ago—our article concluded: "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'" It is time for us to finally answer this question "now!" Consumers can not and should not have to wait longer for a solution to the health care crisis.

Consumers Union recently prepared a report: "The Clinton Health Care Act: What Will it Mean for Consumers." Attached to our testimony is the report's summary of 25 suggestions to improve the Health Security Act. Also attached is a copy of Consumers Union's "Five/Five Plan"—five key provisions to preserve against the pleas of special interest groups and five key provisions that should be improved to better serve consumers.

The remainder of our testimony addresses the issue of the need for comprehensive benefits that are explicitly listed in the legislation.

CONSUMERS WANT COMPREHENSIVE HEALTH CARE BENEFITS

When Consumers Union commissioned a Gallup survey in April 1993, we received a very clear message from consumers: **they want comprehensive health care benefits.** Virtually all (close to 90 percent in each case) of those polled favor universal access to a comprehensive health plan that includes: doctor care, hospitalization, prescription drugs, well-child visits and immunizations, nursing home care, long-term care at home, mental health treatment, dental care, prenatal care, and vision care. When asked about the possibility of phasing-in health care benefits, at least 75 percent of those surveyed wanted **each of these benefits** phased-in within four years, with a strong preference for phasing in doctor care, hospitalization, well-child and immunizations, prenatal care, and prescription drugs **within two years.**

The survey showed a willingness on the part of consumers to wait somewhat longer for the nursing home and home care benefit—with 50 percent of those polled preferring phase-in within 2 years, an additional 30 percent preferring phase-in within 4 years, and an additional 10 percent supporting a more gradual phase-in of these long-term care benefits. Support for inclusion of long-term care benefits came not only from people over 65, who are most likely to need the benefit in the

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of *Consumer Reports*, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports* with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] "The Wagner Bill and Mr. Gannett," *Consumer Reports*, April 1939, p. 20 and "By Popular Demand," *Consumer Reports*, February 1939, p. 32.

[3] "Bureaucracy in Medicine?," *Consumer Reports*, April 1946, pp. 110–111.

near future: fully 91 percent of 18 to 44 year-olds favor including long-term care (both nursing home care and home care) in a benefits package.

CONSUMERS NEED COMPREHENSIVE HEALTH CARE BENEFITS: THE PRIVATE MARKET IS NOT UP TO THIS IMPORTANT JOB

In order to achieve true health security, benefits must be comprehensive. Each family has its own unique health profile and its own set of health care needs. Whether your health need be for a cancer operation, physical therapy to improve the quality of life of a child with cerebral palsy, a measles shot (and other immunizations) to prevent chronic illness in the future, home care for a grandmother with Alzheimer's disease, insulin for diabetes, or medicine to control high blood pressure, every family needs health care of some kind. High deductibles or lack of coverage can present financial barriers to care. For example, preventive care such as childrens' checkups and immunizations are typically not covered by indemnity policies. As long as there are gaps in coverage, we can be sure of unacceptable experiences where the lack of coverage prevented needed treatment and resulted in poor health outcomes or more expensive treatments. If a child's family can not afford needed medicine to control asthma, this child could very likely end up in the emergency room with an asthma attack that is not only life-threatening but also expensive to treat.

The private insurance market is not designed to come to your assistance when you need help. The private market is designed to maximize profits for insurance companies. The cliche that you can't buy fire insurance when the barn is already burning applies to health insurance—once a family needs long-term care, insulin for diabetes, chemotherapy to treat cancer, etc., insurance companies prefer not to take your call. It's clear that what is best for insurance companies is not what's best for sick consumers.

Only a comprehensive, guaranteed benefits package, covering everybody (regardless of age, health status, income status and employment status) will assure that the gaps that exist in today's health care system will be closed. It is time to face the facts. Children need their measles shot to prevent serious chronic illness. Pregnant women need prenatal care to avoid having a low birth-weight baby that will be treated at a cost ranging from $14,000 to $30,000, or even higher. Kids need early treatment for asthma to avoid that trip to the emergency room. Grandparents with Alzheimer's disease (and their families) need some assistance so that they can remain at home.

"CADILLAC" HEALTH CARE COVERAGE IS A MYTH

There has been some discussion recently of the need to avoid "cadillac" health care protection in favor of more modest coverage. I would like to dispel the myth that there even is such a thing as a "cadillac" plan. Even supporters of the notion of a scaled-back standard benefit package are hard-pressed to identify benefits that should be excluded. The guiding principle should be the necessity of the medical care. While cosmetic breast implants and nose jobs would fail to pass the medical necessity test, benefits like prescription drugs, mental health care, and long-term care would be covered. An operation to cure cancer is essential to the cancer victim, just as insulin is essential to the diabetic. It is difficult to argue against inclusion of mental health benefits, or that an elderly person afflicted with Alzheimer's disease should be forced into poverty before receiving any assistance with home health care bills or nursing home bills.

Designing a barebones benefit package does not dramatically reduce total national health care costs. For the most part, a minimal benefit/high deductible plan would merely shift costs from the population as a whole (based in large part on ability to pay) to people who are sick and must face high out-of-pocket costs. The net effect: creation of financial barriers to care, reduced access to necessary care, and higher health costs when lower-cost early treatment is foregone, leading to later high-cost emergency treatment and/or intensive high-tech treatments.

CONGRESS SHOULD NOT LEAVE THE DESIGN OF THE BENEFITS PACKAGE TO A BENEFITS COMMISSION

Only two bills before the Congress—the Wellstone/McDermott single payer bill and the Administration's Health Security Act—spell out a comprehensive benefits package. Other bills include broadly described benefit packages (that do not even

include prescription drugs[4] and long-term care) and then delegate benefit decisions to a National Benefits Commission (S. 1770, Senator Chafee); a Health Care Standards Commission (S. 1579, Senator Breaux), the National Association of Insurance Commissioners (S. 1533, Senator Lott),[5] and the Department of Health and Human Services/state insurance commissions (S. 1743, Senator Nickles).[6]

A health reform bill with an unspecified benefits package doesn't make sense—you simply don't know what you're getting. Consumers Union would never recommend a consumer buy any insurance policy without reading the provisions that specify coverage. Passing the buck to a commission threatens to reduce the health benefits many people have worked so hard to attain. In order for consumer-friendly health reform legislation to pass in this Congress, broad consumer support is needed. How can consumers support a bill without knowing its key provisions? Consumers need to know that they will not be losers under health reform. They need to know that their health benefits will not be cut. This is true both for consumers with employer-provided health benefits and for low-income consumers who are now on Medicaid. It is crucial that the Congress spell out the benefits in the bill.

If Congress defers to either a national commission or the states, consumers can be sure that special interests will work to assure a benefits package in their own interest. The design of the benefits package is simply too important for Congress to pass the buck.

COMPREHENSIVE BENEFITS WILL BE MEANINGLESS IF COMBINED WITH A CATASTROPHIC INSURANCE POLICY

The promise of comprehensive benefits will be hollow if, as in the Chafee, Lott, and Nickles bills, consumers can buy a catastrophic insurance policy, with a $2000 or $3000 deductible, and be considered "insured." A $3000 deductible does not deliver preventive care to children, $2500 worth of insulin to a diabetic, or many other pressing health care needs. What it means is that many low- and middle-income families will not get access to comprehensive health care, because they won't be able to afford it. Instead, they will end up with an unfunded Medical Savings Account and a catastrophic policy with a $2000 or $3000 deductible. Financial barriers to health care will continue for these families.

IF GUARANTEED BENEFITS ARE NOT COMPREHENSIVE, THERE WILL BE A BURGEONING SUPPLEMENTAL MARKET

If Congress—or even an outside benefits commission—designs a barebones benefits package, the market response is both predictable and alarming. Insurance companies that are excluded from participating in health alliances (probably because they are less efficient and provide less value) will rush in to find their market niche—the supplemental market. Employers searching to maintain benefits previously provided will seek out supplemental policies. Individuals that want comprehensive policies will try to buy a policy. All of the problems that have plagued the health care market—and that plagued the medigap market for 25 years before Congress enacted a very successful reform package in 1990—will be continued in the supplemental market. There will be pre-existing conditions exclusions, denied coverage, frivolous variations in policies. The bottom-line will be a multi-tiered health care system, with the lucky getting barebones coverage plus supplemental coverage, and the unlucky relegated to barebones-only protection. The poor will continue to face financial barriers to needed health care, and their costs will be shifted to others.

IF COVERAGE IS VOLUNTARY, COMPREHENSIVE STANDARD BENEFITS WILL NOT GUARANTEE SECURITY

The Congressional Budget Office estimated that last year's version of the Breaux/Cooper bill would leave 25 million people uninsured in the year 2000. Other bills had higher numbers. H.R. 5919 (Congressman Michel) would leave 39 million people

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[4] S. 1743 would include prescription drugs in the catastrophic benefits package; but the $1000 (individual) and $2000 (family) deductible for a catastrophic policy makes this inclusion meaningless for many consumers.

[5] S. 1533 does not call for a standard benefits package, but requires insurers to offer small employers a choice of three plans: standard coverage, catastrophic coverage, or a medical savings account. The NAIC would determine the actuarial value of coverage. Insurers must offer packages that have benefits within 5 percent of the actuarial value calculated by the NAIC.

[6] The benefit package for catastrophic benefits ($1000/individual and $2000/family deductible) would include medically necessary acute care, physician. services, inpatient, outpatient and emergency hospital services and inpatient and outpatient prescription drugs, but not required to include preventive services, mental health and substance abuse, or long-term care services.

uninsured in the year 2000 [CBO]. A voluntary plan—without an employer mandate—simply does not offer the security that consumers want and need. A comprehensive benefits package is meaningless to you if you are one of the 25 or 39 million people left without any insurance at all. Many supporters of a voluntary approach proclaim the fact that their bill restricts "pre-existing condition exclusions." But in fact, pre-existing condition restrictions will continue to exist under reform that is voluntary. As long as there are "pre-existing condition" periods of six months in the voluntary bills, children with diabetes, children in need of therapy, pregnant women, and millions of others who get sick, will continue to be victims of the gaps in the system. And yet without these pre-existing condition restrictions, consumers will be have an incentive to buy health insurance only when they get sick. A voluntary reform approach simply cannot close the health care gaps and end the suffering of children and adults who are left out of the system.

CONSUMERS WANT FREEDOM-TO-CHOOSE HEALTH CARE PROVIDERS

Freedom to choose their health care provider is one of the most highly valued features that consumers seek in the health care system. The April 1993 Consumers Union/Gallup poll found that 85 percent of consumers feel that choice of doctor is important. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Consumers want to be assured that if serious illness strikes, they will have access to the highest-quality specialist and specialized treatment centers.

Congress can meet consumers' needs by assuring access to all consumers to a fee-for-service health plan at a fair price and by making sure that consumers who enroll in HMO's and other networks are guaranteed a fairly-priced point-of-service option. A sure way to alienate millions of consumers would be to create financial incentives that will herd them into managed care coverage that denies them the ability to select their providers.

CONSUMERS NEED COMPREHENSIVE INFORMATION ABOUT HEALTH PLANS AND PROVIDERS TO ALLOW FOR FULLY INFORMED CHOICE.

Freedom to choose providers or health plans is a hollow freedom in the absence of comprehensive information and consumer education about providers and health plans. Today's marketplace is devoid of this type of information—with the result that consumers enroll in HMO's, for example, that they would not choose if they were aware of their high disenrollment rate. They select surgeons to operate on their child without knowledge of the surgeon's medical malpractice record.

Standardization of health care benefits is the basic building block for making it possible for consumers to understand their choices in a reformed health care system. This Committee understood the benefits of standardization when it took the lead in enactment of medigap reform in 1990. In 1990, Congress replaced the confusing medigap market where frivolous variation in policy terms was the rule, with a standardized market in which seniors can now make apples-to-apples comparisons of policies. In order to achieve standardization of the reformed health care market, it is important that all consumers be covered by the same standard benefit package—regardless of whether they work for a large company, a small company, or are self-employed or unemployed.

It is also crucial that consumers—most of whom will have more choices than they now have since their employers select their coverage—have information about health plans in new "report cards." These report cards would include invaluable information about consumer satisfaction, disenrollment statistics, complaint statistics, qualification of primary care physicians and specialists, qualification of hospitals, provider turnover, financial condition and outcome/performance measures such as hospital mortality and immunization rates. Consumers also need complete and accurate information about providers' medical malpractice experiences. They need information about recommended immunization schedules, other recommended preventive care, and information about steps they can take to improve their health.

Congress should build in to health reform better consumer information about treatment choices. Recently, efforts have been made to better educate men better about non-surgical alternatives for treating prostate cancer. Women need full information about treatment choices for breast cancer. Not only can these efforts improve consumers' quality of life, but they also can save money for the health care system.

Consumers will also have choices to make about which cost-sharing arrangement best meets their needs and about which supplemental policy, if any, to buy. Congress should extend counseling services beyond seniors (adopted as one of many path-breaking provisions in medigap reform) and provide objective sources of advice about health insurance to all consumers. In addition, it is essential that Congress

apply the regulatory reforms that work so well in medigap insurance to both the cost-sharing market and the supplemental benefits market. These include standardization of benefits, restrictions of pre-existing condition exclusions, open-enrollment periods, and community rating.

CONGRESS SHOULD BUILD IN CONSUMER PROTECTIONS TO CONSTRUCT A HEALTH CARE SYSTEM THAT IS ACCOUNTABLE TO CONSUMERS

A bottom-line health reform issue for consumers is: is the nation's health care system accountable primarily to consumers or to the profit/loss statements of insurance companies, pharmaceutical companies, and health care providers?

There is no question about the need for consumers to be encouraged to take responsibility for their health and to do all in their power—through diet, exercise, preventive health care and more—to improve their health and the health of their family members. They should not be forced to resort to devices such as bunching medical expenses in one year to get coverage, or stressing their child's allergies in order to get coverage for a regular check-up that should be covered by any health plan.

Similarly, we need to remove incentives for insurance companies to game the system—to select the best risks, to exclude coverage for pre-existing conditions, and to locate their offices in areas populated by healthier consumers. It is important to recognize that substantial exclusions for coverage for pre-existing conditions—for periods of six months to a year—are built in to all the health reform proposals except for the Administration bill and the single-payer bill. And in the absence of a truly universal system with full community rating, efforts to adopt regulations against the financial interests of insurance companies will result in more bureaucracy and policing against gaming-the-system than any one wants to see in a reformed health care system.

Some of the elements of a health care system that would be accountable to consumers include: (1) full representation of consumers on any regional alliance boards AND health plan boards; (2) uniform treatment protocols—and uniform coverage of experimental treatments—within each regional alliance, so that health plans provide truly standard coverage; (3) cost controls on public and private health spending, and on prescription drug prices; (4) an appeals mechanism based at the alliance level, minimizing incentives for profit-maximizing health plans to deny needed medical care; (5) true universality—covering everyone—with fair financing that removes financial barriers to health care and requires an employer contribution; and (6) a real option for states to adopt a single payer health care system.

In sum, the popular slogan regarding crime control "3 strikes and you're out" can be applied to health care reform:

—**Strike one:** make participation (and employer contribution) **voluntary;**
—**Strike two:** pass the buck on defining **benefits** to an outside commission;
—**Strike three:** encourage **catastrophic** policies with a $3000 deductible.

Any one of these crucial mistakes will totally undermine health care reform, and result in gaps in coverage and continuing suffering, lack of needed health care, and financial barriers to care. We urge you to avoid these mistakes, and assure that universal, comprehensive health care benefits become a reality.

Thank you very much for providing Consumers Union with the opportunity to present our views.

25 WAYS TO MAKE A GOOD PLAN EVEN BETTER RECOMMENDED CHANGES TO THE HEALTH SECURITY ACT CONSUMERS UNION

1. Make the benefits provided by health plans truly standard. Require all health plans in—any regional alliance to have the same treatment protocols, including policies toward experimental treatments.
2. Require the alliances to handle disputes and appeals for denied treatment.
3. Integrate all segments of the population into a single system with a global budget within five years.
4. If market conditions warrant (an area has too few high-quality, low-cost health plans available), require alliances to create a Medicare-buy-in type of option that allows consumers to get coverage outside of the insurance industry.
5. Expand benefits to include nursing home care, expanded home care, more extensive mental health care, and care for children with congenital problems.
6. Require that alliances limit fee-for-service plans to one in order to achieve administrative cost savings and avoid risk selection problems.
7. Limit the difference in cost between fee-for-service plans and the average premium plan so that low- and middle-income consumers can enjoy freedom-of-choice of health care providers. (This is especially important for migrant workers.)

8. Protect low-income consumers by reducing the portion of income that must be spent on premiums to 2 percent, by expanding the premium discount for low-income consumers, and by reducing or eliminating the cost-sharing required of low-income persons.
9. Standardize the supplemental benefits market.
10. Provide the National Health Board with authority to regulate—and roll back—prescription drug prices.
11. Give the National Health Board the authority to set minimum quality and access requirements for health plans.
12. Eliminate the antitrust exemption that allows doctors to rig bids.
13. Modify the medical malpractice reforms so that they serve consumers' interests.
14. Establish a national guaranty fund for health plans. This fund would pay outstanding policyholder claims in the event of company insolvency.
15. Regulate health plan finances to protect consumers. Specifically, expand federal capital and surplus standards to cover all health plans and health alliances; health plan assets should be separate from the rest of a company's assets. Antitrust laws should be—extended and exemptions should be limited to prevent companies from using predatory pricing practices in non-health portion of business to bolster health plan business.
16. Expand counseling programs (that now serve senior citizens) so that all consumers have access to an objective source of advice about selection of health plans.
17. Improve the regulation of the private long-term care insurance market.
18. Exempt low-income senior citizens (those earning up to about 150 percent of the poverty line) from the increase in the Medicare Part B premium.
19. Provide for nationwide risk adjustment, so that the costs associated with high-risk populations are spread fairly. This is the only way that small groups of high-risk populations (who may be grouped within one regional alliance) will not pay disproportionately higher premiums. In addition to health problems, risk adjustment should include non-health related factors that can restrict access to health care, such as transportation, translation, and other related services.
20. Adjust the subsidy for early retirees so that those with incomes substantially above the poverty level pay their fair share of health care costs.
21. Ban hospital indemnity and dread disease policies.
22. Ban variations on the standard benefit package.
23. Require insurance companies to have legitimate consumer representation on boards; expose insurance company executives' salaries to public scrutiny.
24. The plan should be consistent in how it deals with supplemental insurance policies designed to cover cost-sharing, or the out-of-pocket expenses a consumer would face. Either this coverage should be banned across the board, or it should be allowed under both low cost-sharing plans and high cost-sharing plans.
25. Impose an income tax surtax, a tax on new hospital revenues that are created by reduced spending for uncompensated care, and increase the tax on corporate alliances to pay for additional benefits and subsidies.

FIVE/FIVE PLAN FOR HEALTH CARE REFORM, CONSUMERS UNION, FEBRUARY 4, 1994

Congress should fight hard against special interests to preserve these important provisions of the Health Security Act:
1. Universal health care must be a reality within three or four years.
2. Cost containment through limits on public and private spending must be kept.
3. Employers must be required to contribute to the cost of their employees' health care.
4. Keep the benefits package comprehensive.
5. Maintain the state single payer option.

Congress should improve the Health Security Act to make it better serve the needs of consumers:
1. Protect low- and middle-income consumers from facing financial barriers to care or burdensome premiums.
2. Increase accountability to consumers by prohibiting insurance companies from varying the benefits offered within each alliance, by shifting the appeals process outside the insurance company, and by reducing the ability of insurance companies to deny coverage.
3. Make freedom-of-choice of provider a real option for people of all income levels by requiring all health alliances to offer a fee-for-service plan that costs little more than the average cost plan.
4. Include the blueprint for phasing-in nursing home benefits and expanded community care benefits.

5. Give the National Health Board the authority to regulate prescription drug prices that apply to all Americans.

By Popular Demand

"People in general are beginning to take it for granted that an equal opportunity for health is a basic American right. They are thinking just a little ahead of the lawmakers and even, I fear, ahead of the practitioners of public health and clinical medicine. It has been the insistence of the people back home that has pushed through both houses of Congress, without a dissenting vote, our recent legislation for cancer and venereal diseases. Though the issues have been over-complicated and the difficulties over-magnified, common, ordinary folk are beginning to get the idea that we know how to do a great deal more than is done to keep them well and cure them when they are sick."

THOSE are the words of Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, to the National Health Conference in Washington last July.

That Conference, composed of nearly 200 delegates from government and public health departments, labor, farm and consumer groups, medical and civic organizations, was called, at the suggestion of President Roosevelt, by the Interdepartmental Committee to Coordinate Health and Welfare activities.

Its purpose: to obtain "attention and constructive criticism" for the Committee's report on national health.

The report included a suggested program calling for expansion of public health and maternal and child health services, of hospital facilities and of medical care for the medically needy.

It suggested a form of health insurance and it proposed disability insurance to cover loss of wages during sickness.

It recommended the participation and cooperation of Federal, State and local agencies.

It in no way sought to establish socialized medicine, as charged by alarmist critics. It did propose to apply direct methods of dealing with a situation in which some 40,000,000 Americans were getting inadequate medical care.

THE Washington Conference did more than accept with enthusiasm the proposals of the Committee. It laid the groundwork for action to carry them out.

Said Dexter Masters, Consumers Union delegate, in summing up his address to the Conference:

"I propose . . . that the representatives of the trade unions go back to their trade unions and work for strong and immediate action to turn these recommendations into law; and that the representatives of the farm organizations and the women's clubs go and do likewise. . . ."

The delegates did go home and work—and the newspapers and the magazines in the months that followed told the nation the story of the Conference. But during the same months the hierarchy of the American Medical Ass'n was working, too. And pretty soon the press of the country was telling another story—how the U. S. Dep't of Justice was taking action against the A.M.A. for trying to create a monopoly in the health-and-life-saving business.

Now never in the history of the human race has curing the sick been regarded as an appropriate field for monopolistic practice; nor has the art of healing been considered a product which businessmen could, in decency, try to corner. People were a trifle shocked by the A.M.A.

And, as between the A.M.A. and the recommendations of the Interdepartmental Committee, the American public has wholeheartedly and unmistakably lined up. The difference of opinion between the public and the A.M.A. is sharply underlined in the matter of health insurance. The medical businessmen, having paid a certain amount of lip service to other recommendations of the Committee, came out flatly against health insurance.

But a nation-wide survey by the American Institute of Public Opinion has shown that no less than 32 million Americans are so eager for health insurance that they would be willing to pay $3 a month for it.

THERE is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science.

The only question before the country now is:

"How soon?"

Last month the report of the Interdepartmental Committee was sent to Congress by the President. It—or the substance of it—will next appear as a National Health bill, probably sponsored by Senator Wagner of New York.

This National Health bill can die or be delayed in committee; can be defeated in either Congressional house; can be emasculated at almost any point in the legislative process. Whether or not it is so delayed, defeated or weakened depends on how loudly and clearly the people ask for what they want; depends on that popular demand which "pushed through both houses of Congress, without a dissenting vote, our recent legislation for cancer and venereal diseases."

Watch for the National Health bill. It should be introduced within the next 10 days. When it is, write to your representatives, to President Roosevelt, to Senator Wagner—tell them of your support, demand the bill's passage. Let's have a sensible and humane health program —and soon!

PREPARED STATEMENT OF FRANK B. MCARDLE

Mr. Chairman, and Members of the Committee, my name is Frank McArdle. I am a consultant with Hewitt Associates LLC and I manage our firm's Research office here in Washington. I have been addressing employee benefit issues for over 18 years and have focused the majority of my attention on health care reform in the past few years. With me today is Ken Sperling of Hewitt Associates, from Rowayton, Connecticut. Ken is one of our lead consultants working directly with employers on health care plan design and cost management. While Ken has worked with health plan design in many parts of the U.S., he is currently most actively working with employers and employees in New York, New Jersey, and Connecticut.

Hewitt Associates is an international consulting firm specializing in the design, financing, communication, and administration of employee benefit programs. We provide consulting services to over 75 percent of the Fortune 500 and have an active client base of over 2,000 employers. We provide these services through over 60 offices worldwide, including offices in Michigan, Minnesota, Missouri, New Jersey and New York

We are honored by your invitation to be here. The subject of this hearing is one of the most difficult and important ones you will have to address as part of national health care reform.

Many of the health care reform proposals envision a standardized health care benefit package. Our assigned role today is not to advocate to the Committee what specific benefits should be included or excluded from any standard package. Our objective is to describe how the typical employer develops and continually readdresses the design of its health benefit plan, the typical health benefits offered today by employers, and how designs may vary in particular regions of the country.

HOW EMPLOYERS DESIGN HEALTH BENEFIT PLANS

Benefit plan design is not static, nor is it common across all companies. It is continually changing, continually trying to self-perfect, and continually adjusting to the domestic and international marketplace that surrounds it. One reason that plan design is in constant change is because whenever there are new design features that go into widespread use, the health care marketplace reacts fairly quickly, new techniques that may work well in one year may be completely ineffective or even counterproductive a short time later. That is one of the reasons we see tremendous variety in plan design from one company to the next.

Today we will discuss the process different types of employers follow in setting and revisiting plan design, provide examples of the results of this process, and briefly describe how innovative ideas enter the market and spread throughout it.

A key thing to remember is that the decisions about plan design are very important in determining the overall cost of the package and in determining the quality the mix, and the levels of health care services used by employees and their families. At least for the larger companies, those decisions are not made by the "outside" design consultant. Instead they are decisions organic to the employer/employee community that the benefit plan will serve. The outside consultant really steps out of the process when the company's culture and philosophy take over. For example, we can provide a company with the prevalence and cost impact of covering fertility procedures such as in-vitro fertition, but whether the company actually includes this in their health care plan is their own decision, driven by their attitudes, values, and feelings of responsibility to their employees. We're not saying financial impact doesn't come into play but the financial decisions are just as much focused on the allocation of available dollars to be most effective among different design features.

Degree of Control

If you took a snapshot of employers at any point in time, you would likely see three different varieties of the design process, differing by the degree of control an employer has over the final product. For purposes of our discussion, the three types of companies can be categorized as:

- Small employers,
- Large employers, and
- Innovators.

Small employers (those with less than, on average, 100 employees) have limited flexibility when it comes to benefit design. In order to minimize administrative overhead, insurance companies offer "standard" packages that are fairly comprehensive, administered by a third party and have a core level of cost controls. A small company's claims experience may or may not be blended with many other small companies in the insurer's pool. The small company's plan design decisions are usually related

to the tradeoff between premium cost and level of coverage, much like you or I would decide what automobile or homeowner's insurance to purchase. The small company must also decide how the premium will be shared between employer and employee, and the amount (and the technique) of payroll deductions that will apply if employees are to contribute towards the premium cost.

As the size of the company increases, the degree of control the employer has in setting the plan design parameters also increases. Large employers may follow a disciplined process for translating their business goals into benefit plan design. Whether formal or informal, many employers use a process designed to deliver targeted, fact-based decisions.

First, the company examines its overall business objectives. These broad goals are then translated down to a human resources level. From there, the process "drills down" further to total compensation objectives (since employer-sponsored benefits are, in large part, a form of total compensation). Specific benefits objectives next emerge, and finally the process can be narrowed to health care objectives. This linking of benefits to business goals, while not used universally has been an important starting point for many large companies. We also should note that it is rare for a large company to be designing its benefits "from scratch." Most large companies have provided health care coverage to employees for decades, so the redesign effort is much more common than the initial design process.

The most common next step is for the company to examine the historical data on the actual health care experience of its employees. This is typically accomplished by an analysis of the claims for reimbursement that have been submitted for each employee. Technological and other advances in data reporting and analysis have made it possible for employers to understand the real drivers of their health care costs. Instead of implementing the most popular set of cost constraints that may have no effect on a particular company's problems, concrete utilization and charge patterns allow the company to focus its design modifications on the elements that have the greatest potential return.

Large companies then select among various design alternatives that have the potential to achieve the desired results. Because each company has different cost problems and each has its own culture, demographic makeup, and geographic location, different companies will choose different solutions. The result is a system that is by no means standardized, but in aggregate attempts to provide cost-efficient comprehensive benefits. Most often, this process is conducted on an annual basis, and takes into account the likely return on investment (both quantitative and qualitative), administrative complexity, fit with the culture of the organization, and amount of disruption to employees. Most companies seek to maximize return on investment while minimizing employee disruption. It is common, for example, to find employers going to great lengths to match the employees' current physician and hospital utilization with potential managed care network providers—seeking to choose the network that disrupts the least amount of employees from their current provider relationships.

A competitive analysis is typically included in this process as well, recognizing that the ability to attract and retain employees is a major reason for offering and sponsoring employee benefit plans. Companies gather "benchmark" information about the plans offered by other employers in the geographic locations in which they operate, as well as from other companies in their industry. Design parameters and employee contribution levels are frequently included in this evaluation.

Many companies seek employee input as a part of the design process, either through surveys or small group meetings called "focus groups." This employee involvement can give the employer powerful information about employee preferences, which will facilitate some of the difficult choices that lie ahead and help the employer decide where its health care expenditures will likely result in the optimal employee satisfaction.

Final decisions are made regarding changes to design parameters, employee contributions, and cost management programs, and the changes are communicated to employees and then implemented. A methodology is put in place to measure the success or failure of the changes.

Upon completion of the evaluation, the process begins all over again. As we shall see, the end results of this process are unique to each company.

The third type of company is the innovator. This could be either a small or large employer, although most are larger companies. These are companies that have the resources and market influence to experiment with new ideas. These employers are usually self-insured, i.e., they do not use an insurance company to insure—or design—their plan. They follow much the same process as other large companies, but when looking at possible alternatives they do not bind themselves with existing solutions. They frequently enter into a cooperative sharing of ideas with their internal

staff, health care management vendor, and providers, such as the large hospitals in their major locations. The innovative employer is really the "new product development" research arm of the health care benefits industry. Successful experiments are regarded as "best practice" examples which then expand to other, more conservative large employers whose data and culture support imitation of the initiative. As the idea matures, more concrete information about its effectiveness becomes available, and insurance companies become comfortable with its administrative implications, the idea is standardized, packaged, and finds its way into the menu of options offered to the small employer market segment.

A perfect example of this evolution was the point-of-service managed care network, or "combination plan" (as the proposed Health Security Act calls it). AlliedSignal was perhaps the first nationally recognized employer to experiment with this concept back in 1987. Their successful experience soon created market demand from other large employers, and by 1991 nearly every major insurance company was offering this option to their corporate clients, and by 1994 so are many HMOs—Kaiser Permanente being the most recent example. Even the Health Security Act's proposed standard benefits package mandates that a point-of-service option be offered by every regional alliance in the country. In just seven years this health care delivery model has moved from the laboratory environment to the mainstream.

Other innovations we are seeing in today's marketplace include:

- Using health care quality and efficiency measures to motivate employee choice of high quality, comprehensive health plans;
- Creating customized networks of hospitals and physicians based on the provider's ability to use resources efficiently without sacrificing health outcome;
- Empowering employees to use company subsidies to create their own benefits programs that meet their individual needs at various points in their life cycle (the so-called LifePlan Resources technique);
- Incorporating employee satisfaction measures into the evaluation, selection, and ongoing monitoring of company-sponsored health plans; and
- Using state-of-the-art managed mental health programs to provide more generous benefits at lower cost.[1]

These are just a few of the many experiments being tested in the changing health care marketplace of 1994. Those that prove to be successful will become more widespread and institutionalized in the coming years through the continuous improvement and self-perfection process. There will likely be other initiatives whose effectiveness is overtaken by market forces. As the measurement process identifies this evolution, these programs will be replaced. Again, we can expect the innovative companies to remove them first, followed by large companies in general, and then by small companies through the actions of their insurance carriers.

THE HEALTH CARE PLAN OF TODAY

Health care plans began to get more complicated in the 1980s. Employers started to realize that the typical family consisting of the husband working and wife at home with two children no longer represented the actual needs of their employees. Employees wanted and demanded more choice in their benefit package so they could select the best combination of benefits for their situation. Thus, the concept of "flexible benefits" was created.

In addition, as health care cost pressures mounted, companies began to alter the level of benefits provided. Typical changes were to apply deductibles and coinsurance to all kinds of expenses, including hospital and surgical.

For the past 20 years, Hewitt Associates has maintained a data base of benefit plan provisions. Currently, we have provisions for the salaried employees of over 1,000 major employers (SpecBook™). In addition, we maintain data on the provisions for the hourly and union employees of more than 200 major companies. These employers together provide benefits to more than 20 million employees and 35 million of their spouses and dependents. Many employers in our data base offer their employees a choice of medical plans.

As Figure 1 shows, almost 9 out of 10 employers offer more than one medical plan. Where more than one plan is offered, alternative plans might be HMO options, a PPO or other managed care option, or an indemnity plan with higher deductibles and copays—so the employees can choose the coverage that benefits their personal situation.

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[1] See Hewitt Associates' testimony on mental illness and substance abuse benefits presented to the House Energy and Commerce Committee, Subcommittee on Health and the Environment, December 8, 1993.

The typical medium- to large-size employer offers its employees at least one indemnity plan choice and one HMO. The typical indemnity plan looks like the following:

- Comprehensive major medical plan design (all services are paid under the plan's provisions);
- Annual front-end deductible of around $200 per person;
- After the deductible, the plan will pay 80 percent of covered expenses;
- The employee will have his or her out-of-pocket expenses limited to about $1,500 (including the deductible) per person;
- Employee contributions range from $-0- (15 percent of employers) to over $50 per month for single coverage and from $-0- (9 percent of employers) to over $150 per month for family coverage; and
- Employee contributions are paid on a pretax basis.

Another way to state the above benefit coverage is that the plan pays 80 percent of covered expenses from $200 to $6,700 and 100 percent of covered expenses above $6,700.

Comprehensive plans will typically cover all medical expenses that are incurred due to injury or illness, as long as the fees charged by providers are not out of line with what other providers charge. This would include hospital stays, physician fees, X-rays and testing, mental health care, and prescription drugs. It would typically exclude preventive care, cosmetic surgery, experimental procedures, and other expenses that were not due to injury or illness. The plans would also exclude expenses that were paid under another plan (e.g., veterans' hospital or workers' compensation).

HMOs generally provide "richer" benefits than indemnity plans and also offer the luxury to the employee of no claims forms to be filed. The typical HMO plan of benefits provides 100 percent coverage of all services except for nominal copays per physician visit (e.g., $10 per visit). They will cover the same types of services the indemnity plan does and will usually include preventive services. These higher benefit levels are provided because HMOs negotiate discounted fees from providers, restrict employee choice of providers, and may manage delivery of services more efficiently. In general, HMOs provide lower levels of benefits than indemnity plans do for mental health and substance abuse services.

Figures 2 and 3 provide a graphical illustration of the estimated level of benefits provided under the average indemnity plan and average HMO for each major service category of health care costs. Note that neither of the plans typically pays vision, hearing and long-term care expenses. And both types of plans limit the coverage of mental health and substance abuse costs, but to varying degrees. Usually the employee also gets benefits from a stand-alone dental plan, which is available to HMO and indemnity plan participants alike. Ninety-six percent of our data base employers offer a dental plan. In addition, 36 percent of our data base employers offer a corporate vision care plan, and 10 percent offer hearing care.

The typical coinsurance level for indemnity plans is 80 percent. Figure 2 shows several services being reimbursed at higher rates. The reason for this is that the typical plan will also have an out-of-pocket limit. Therefore, for high cost services (e.g., hospital and surgical), the actual benefit percentage paid is greater than the 80 percent.

On average, when an employer offers employees a choice between indemnity plan or HMO coverage, about 25 percent join the HMO. Figure 4 shows the percent of employees in our data base who have elected coverage under an HMO option where such an option is available. For example, 21 percent of employers in our data base have 20 to 29 percent of their employees enrolled in HMOs.

Regional Variations

Figure 4 is based on our overall national data base. You would get very different results if you looked at specific geographic areas of the country. These regional variations can be subtle but quite important to recognize.

We have attached a table showing variations in plan design among the states represented by many of the Committee members to give you a flavor for how important regional variations may be. Note that most of the data in this table represents the one plan of each employer that covers the most employees; this may be an indemnity plan, a PPO, or an HMO.

We have highlighted some of those differences below.

HMOs have had tremendous success in enrolling participants in California. So, you would expect much higher percentage of participation in this state. In fact, the traditional indemnity medical plan is the highest-participation plan in only 13 percent of employers in California but is the highest-participation plan in 75 percent

of employers in New Jersey and 71 percent in New York. 31 percent of employers in California and Minnesota have HMO participation of more than half of their enrollees whereas 'none of the employers in New Jersey and 7 percent in New York have over half of their employees in HMOs.

Other plan features tend to have geographic differences too—primarily because of the higher prevalence of managed care plans in certain areas. For example, states where managed care is most prevalent (California and Minnesota) tend to have lower deductibles and other copay amounts. 40% of major employers in California have either no deductible or a deductible of $100 or less compared to 27% in New Jersey and 19% in New York where indemnity plans are more common. Major employers in New Jersey and New York tend to offer higher inpatient mental health/chemical dependency coverage, in that fewer of these employers tend to place limits on that coverage. Deductibles and out-of-pocket limits for New York and New Jersey "vary by pay" 2–3 times more frequently than in other geographical areas, largely because of the high contingent of financial industry employers.

Hourly vs. Salaried Plan Variations

As mentioned earlier, the statistics shown in our data base represent the plan provisions of salaried employees' programs. There are generally variations between salaried employees' and hourly employees' benefit programs. In some cases, hourly employees have greater benefits, especially when represented by a union, and in some cases, hourly employees have lesser benefits.

For example, in our Hourly Plans' SpecBook™, we show 54 percent of the collectively bargained plans are provided to employees (for the employee's own coverage) at no charge. This is in contrast to 15 percent of salaried plans that have no employee contribution.

RECENT TRENDS

During the latter part of the 1980s, employers were subjected to much greater health care cost increases than in previous years. Many employers altered their plans to shift some of their cost increase to employees. These alterations generally took the form of increased deductibles and employee contributions.

In recent years, many employers have begun to truly understand how costs can be controlled, not by cost shifting, but by identifying and managing factors that underlie the costs. Different elements of these factors are finding their way into today's health care plans.

The general movement of larger employers is to manage both the utilization and the price of health care. Depending on the amount of health care that is "managed" by the plan, the employees' freedom to choose their provider and the type of care they can receive from the plan is limited. Figure 5 graphically shows this tradeoff between employer cost control and employee choice.

GLOSSARY—MANAGED CARE MODELS

Pure Indemnity—Fee-for-service plan with no controls on utilization or price.

Managed Indemnity—Fee-for-service plan with utilization review and case management.

Preferred Provider Organization (PPO)—A contractual arrangement between providers and an employer or insurance carrier to provide discounted fee-for-service medical care. In most cases, no primary care physician to serve as "gatekeeper."*

Open-Ended HMO (OEHMO/Point-of-Service Choice)—Arrangement that allows enrollees to make a choice at the point of service either to stay within the HMO network of providers or to receive care (at a higher cost) from non-HMO providers outside of the network. A primary care physician is required and serves as "gatekeeper."

Individual Practice Association (IPA) HMO—A type of HMO that consists of a central administrative authority and a panel of physicians and other providers practicing individually or in small groups in the community.

Group/Staff Model HMO—The "traditional" HMO (such as Kaiser) in which physicians work directly for a single HMO. Under a group model, physicians are typically paid via capitation; in a staff model, physicians receive a salary.

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*Gatekeeper—A primary care physician who is accountable for the total health services of enrollees, arranges referrals, and supervises other care such as specialist services and hospitalization. Gatekeepers are typically used to manage care in HMOs and OEHMOs.

Today's indemnity plans typically have many of these "managed" elements included in their plan designs (e.g., utilization review, concurrent review and preadmission testing). These are often called "managed indemnity" plans because the benefits are based on the typical fee-for-service indemnity plan design but have included some managed elements of reviewing health care delivery.

The other types of managed care plans have different benefits depending on whether a person goes to a doctor who has been pre-approved to provide care under the plan (or is in the plan's network). "In-network" benefit payments are generally higher than if a non-network provider (hospital or physician) is used. The difference in going to a non-network provider may be to pay a higher deductible (e.g., $500 non-network versus $200 in-network) and/or receive less employer-paid coinsurance (e.g., 70 percent non-network versus 90 percent in-network).

The following table shows the prevalence of the reimbursement spreads between in-network and out-of-network benefits, based on the plans in our employer data base (total <100% because some designs cannot be easily categorized):

Spread	PPO	POS HMO
No difference	9%	1%
10% or less	21	8
15%	6	3
20%	30	44
25%	2	4
30% or more	5	36

A key difference between the "preferred provider" plan and the other three plans shown in the graph (point-of-service, IPA HMO and staff HMO) are that under the latter plans, the covered person must have all services coordinated by a "gatekeeper" that is usually a primary care physician. The gatekeeper may refer the patient to other specialists, but he or she has complete control over the patient's care. In a point-of-service plan, the covered person may go outside the network, but he or she will have to pay higher copays. Generally under HMOs, a person cannot use non-network providers with the exception of limited benefits if they become ill or injured while away from home. Therefore, the HMO has the highest limitations on the employee's choice of health care provider.

Most of the managed care plans (the point-of-service and HMO plans) in place today offer almost 100 percent coverage for all health care services if they are performed within the network. However, recently adopted plans have begun to introduce more copays (plan deductibles, coinsurance and office visit copays) because experience has shown increased use of health services unless the employee has a financial incentive not to use the service.

The two key trends that should be considered in developing a standard benefit package are that employers are moving to managed care types of plans, and higher levels of employee copays and contributions are being introduced. Financial incentives are being created to encourage the use of more cost-effective providers, but the employee usually also retains the option of higher or lower levels of coverage.

OTHER DESIGN FEATURES TO CONSIDER

If the Committee is concerned about the potential costs involved with a standard benefit package, here are some additional design aspects that you may wish to consider.

A standard benefit package will need to focus on both cost and utilization to achieve overall cost control

Hewitt Associates maintains several different data bases to support our health care practice. Based on these data bases, we have helped employers design their benefit program to provide health care services to their employees that meet the employers' objectives in terms of cost and quality. We have learned a lot from this data analysis. For example, we have made comparisons of actual costs and utilization of services against expected results. In one case, we noted that the employer had negotiated very attractive discounts with a group of physicians to be included in a preferred provider network. When their actual experience was analyzed, however, there were apparent savings from a price of services perspective, but they were more than offset by higher than expected use of services.

To avoid this problem, the standard benefit package could include items to give employees a financial incentive to seek the most cost-effective care.

The standard benefit package should encourage employers to continue to expand on health promotion initiatives that will ultimately lower health care costs

We can identify lifestyle-related claims that could be prevented. For example, for one employer we noted that they had a higher than average rate of premature and underweight babies being delivered. This indicated that it would be beneficial to offer incentives for prenatal care for expectant mothers.

The standard package may need to allow flexibility on an industry and regional basis

As identified earlier, prevalent benefit practices vary by region of the country. In addition, there are substantial variations by industry For example, retailing typically has lower benefits than manufacturing. The more flexibility that can be allowed in plan design, the easier it will be to win acceptance of the basic changes.

RELATIVE VALUE OF STANDARD PACKAGE COMPARED TO LARGE EMPLOYER PLANS

We have reviewed the actuarial value of the high cost-sharing plan proposed in the President's Health Security Act compared to indemnity (fee-for-service) plans of similar design offered by large employers. Our data base of employer plans used in the valuation includes large companies from a variety of industries.

Out of 487 large companies in the comparison, the Health Security Act's high cost-sharing plan ranked 431st in value (with 1 being the "richest" plan). This means there were 430 companies (or 88 percent) with plans that provide more generous benefits, on a relative value basis, and only 57 companies (or 12 percent) with lesser benefits.

The main reason for the lower value of the initial proposed Health Security Act plan is the low adult dental benefits. If we only focus on the medical plan benefits, excluding dental, the proposed Health Security Act plan ranks 227th. That is, there are 226 companies (or 46 percent) with richer medical benefits than the Health Security Act plan.

Note: These values are for total plan benefits; individual employers and employees pay varying shares of that total cost. In our experience, the degree of employer/employee cost sharing varies more than the plan designs themselves.

Generally, there are also variations between benefit programs for salaried and hourly employees. As we noted above, in some cases, hourly employees have greater benefits, especially when represented by a strong union; in other cases, hourly employees have lesser benefits.

We have not been able to determine the relative value of certain other health care reform proposals because the benefit package is not always specified in the proposed statute, as it is in the proposed Health Security Act.

EMPLOYEE ATTITUDES TOWARD HEALTH PLAN DESIGN

When designing a health benefit package, key employee attitudes should be considered to gain public acceptance. Medical benefits are very important to employees, and therefore any change will evoke very emotional responses. Also, although employees have opted for freedom to choose their own physician over all other considerations (including cost, convenience and quality of care), the importance of choice of provider varies significantly with the type of medical provider. Employees are much less willing to change pediatricians or ob/gyn providers than they are willing to change general practitioners.

Whenever an employee survey is performed that includes questions on importance of specific benefit programs, medical benefits consistently rank number one. Figure

6 summarizes 1993 findings from Hewitt Associates' Perception Index™ data base. It clearly shows that medical benefits are the most important employee benefit.

On another note, when asked why an employee chose a particular medical option, the leading response is the ability to choose any physician. This is over other factors such as cost and convenience. Figure 7 summarizes these responses, also from our Perception Index™ data base.

Thus, based on the above information, the design of the health benefit package should consider whether its application will be so restrictive that employees are directly or indirectly forced to change their current providers, or whether employees should be given a true option to retain their current providers and pay higher costs. Even so, our data indicates that the tradeoff between choice of doctor vs. lower contribution cost will be a tradeoff between the two most important employee concerns.

The table below shows overall findings from our surveys on employee attitudes:

Current Provider	Would you change doctors to save money?		
	Yes	No	No response
General practitioner	50%	43%	7%
Ob/gyn [1]	20	68	12
Pediatrician [2]	18	61	21
Other specialist	31	50	19

[1] Answered only by females.
[2] Answered only by those with children.

SOME CONCLUDING OBSERVATIONS

There currently is no single "standard" health benefit package in the marketplace today. There are typical forms of plans offered, but most employees have a significant degree of choice—choice of plans and choice of medical providers—and they value and appreciate that choice. Therefore, if a single standard health benefit package is imposed on individuals, a wide variety of human experience would be forced down a very narrow funnel. From our experience in designing health care plans, there would be substantial negative employee reaction unless it were preceded by a long and effective educational program to communicate the reasons that there has to be change.

Health benefit packages may or may not contain so-called "ancillary" benefits such as dental benefits or vision care benefits. Regardless of what priority the Congress assigns to such benefits, the fact is that most employees with major employers now get dental benefits as part of their health plans and that the employees highly value such benefits (Figure 6). If a uniform plan design were to cause them to lose access to those benefits, either directly or indirectly (e.g., through taxation), negative employee reaction would be considerable. Thus, it is important to include the value of health care benefits other than medical in determining the "standard benefit package" if that package is to be used for determining the tax deductibility of employer contributions or the employee tax exclusion.

Steps also must be taken to transition employees to a new form of health benefit plan (e.g., a shift to a standard benefit package) in order to manage change. As mentioned earlier, such a shift could be extremely disruptive of existing provider/patient relationships and therefore provoke strong negative reactions from the public.

Alternatively, transitions toward managed care arrangements can also be accomplished on a phased-in basis, which is sensitive to the existing choices of employees and their families. If done properly, over time and by means of financial incentives, a large majority of employees can end up moving to managed care arrangements. But a sudden shift by government decision-making could be too abrupt and provoke too strong of a backlash.

Imposing a single standard benefit package could well result in a loss of benefits for many employees of the type that these employees highly value. If one of the reasons Congress is looking at a single standard benefit package is to contain costs, it is worth considering that there are many other factors besides standard plan design that may have an equal or greater effect in reducing costs.

For example, in our experience, as much as 40 percent of the costs now incurred by employers and employees may be avoidable costs. We have a data base of approximately 7 million lives that helps us calculate, for each employer and each employee population, where the areas of spending are above the norm and, therefore, where savings can be realized without compromising the quality of care. As examples of these avoidable costs, please refer to the "Data Base Findings on Avoidable Costs" in Attachment B.

If the Committee were to pursue strategies to reduce avoidable costs that would result in savings to the federal government and employers, it may obviate the need to impose a single standard package all at once and reduce the risk of public rejection of the reform concepts.

CONCLUSIONS

Mr. Chairman, we hope this information will be of assistance to the Committee as it makes its deliberations.

Like the rest of the Nation, we at Hewitt Associates have heard the call for a larger contribution from private individuals and from the private sector in the resolution of public policy problems. We are prepared to do our part by volunteering our technical assistance as the need arises. Thank you.

Figure 1: Number of plans offered by employers (including HMOs).

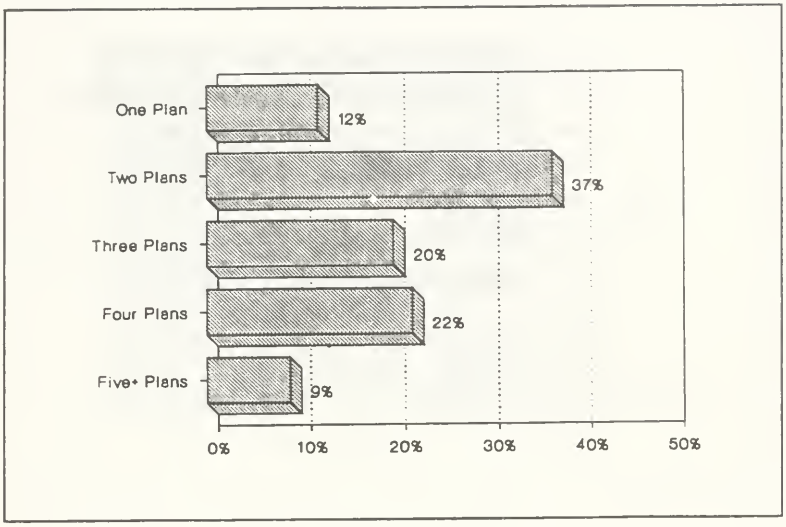


Figure 2: Percentage of covered expenses paid under typical indemnity plan.

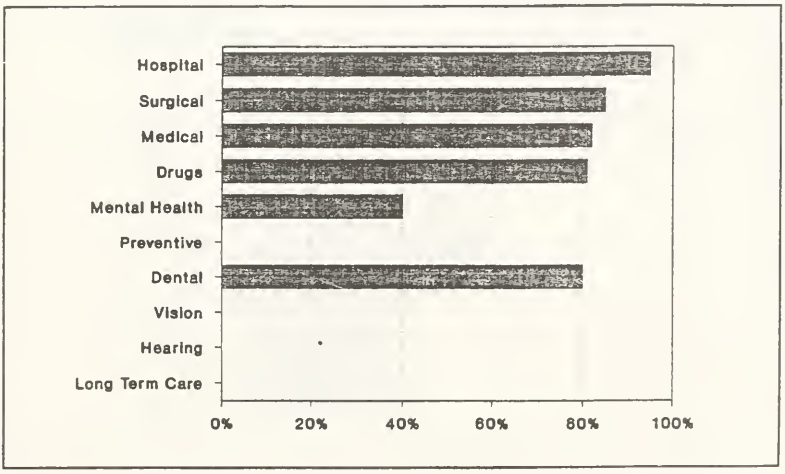


Figure 3: Percentage of covered expenses paid under average HMO plan.

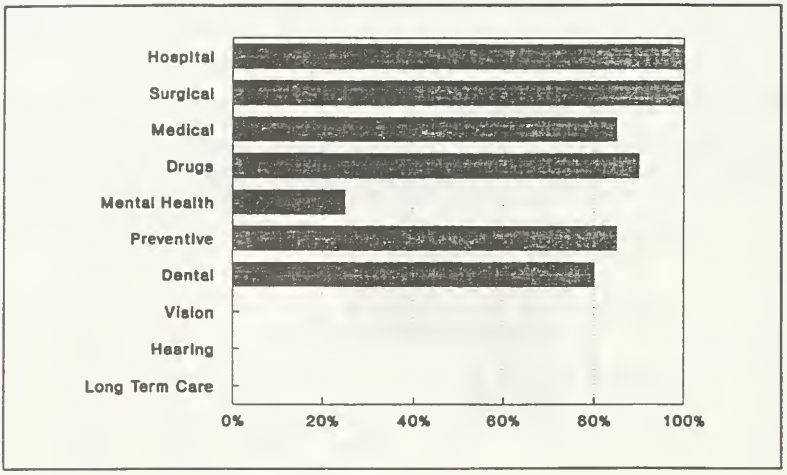


Figure 4: HMO participation.

This table captures the percent of employees who have elected coverage under a standard HMO option.

HMO Participation	% of Employers
Less than 10%	16%
10%–19%	24%
20%–29%	21%
30%–39%	15%
40%–49%	10%
50%–59%	7%
60% or more	7%
	100%

Figure 5: Levels of cost control versus employee choice.

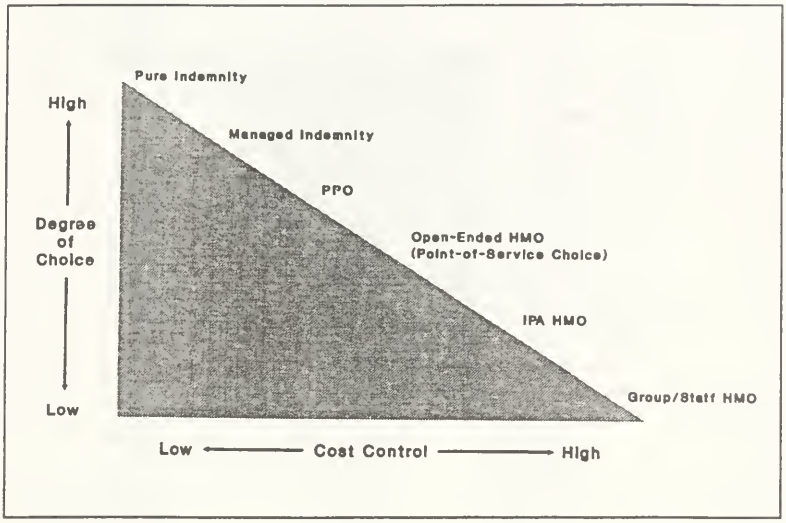


Figure 6: Order of benefit importance to employees.

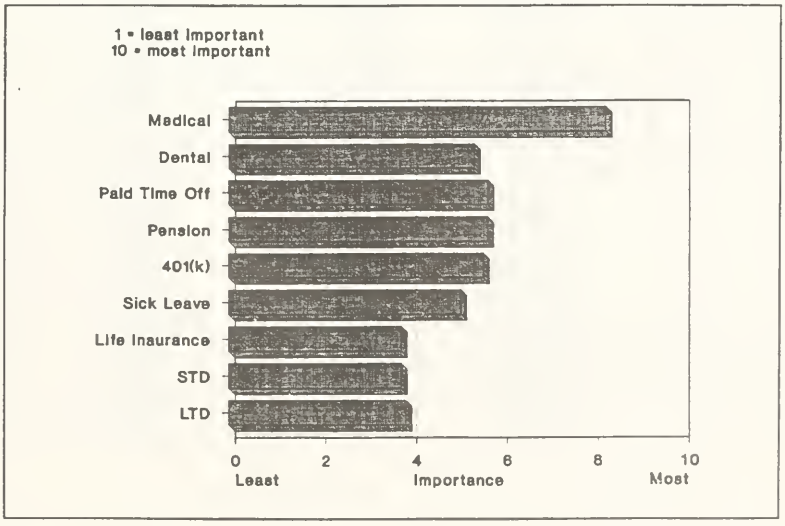
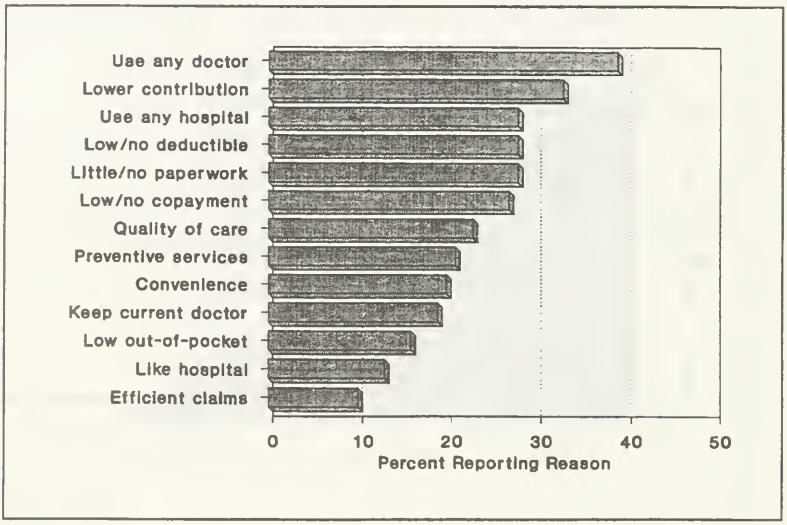


Figure 7: Reported reasons for choosing current medical plan.



	General Industry	California	Arkansas/ Louisiana/ OK/Texas	Iowa/ Kansas/ Missouri	Minnesota	Michigan	New Jersey	New York	CT/Maine/ Mass/RI
NUMBER OF MEDICAL PLAN OPTIONS (including HMOs)	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
One plan only	12%	5%	18%	8%	9%	8%	10%	6%	6%
Two options	37%	41%	33%	46%	38%	34%	43%	44%	31%
Three options	20%	20%	17%	10%	32%	22%	8%	19%	30%
Four options	22%	25%	22%	28%	12%	28%	32%	21%	23%
Five or more options	9%	9%	10%	8%	9%	8%	7%	10%	10%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
TYPE OF PLAN (total exceeds 100% because of multiple plan options)	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
Traditional indemnity plan	67%	37%	68%	51%	68%	83%	88%	86%	77%
PPO plan	41%	74%	44%	62%	50%	42%	12%	17%	36%
POS HMO plan	13%	18%	13%	15%	18%	3%	15%	12%	11%
Standard HMO plan	77%	87%	63%	85%	76%	83%	90%	88%	81%
EMPLOYEE PARTICIPATION IN STANDARD HMOs	(n = 797)	(n = 87)	(n = 64)	(n = 33)	(n = 26)	(n = 30)	(n = 54)	(n = 100)	(n = 57)
Less than 10%	16%	1%	28%	18%	19%	7%	22%	19%	5%
10% – 19%	24%	15%	35%	28%	19%	23%	41%	25%	18%
20% – 29%	21%	23%	17%	21%	19%	30%	22%	27%	23%
30% – 39%	15%	17%	13%	12%	4%	13%	7%	17%	21%
40% – 49%	10%	13%	5%	6%	8%	17%	8%	5%	10%
50% – 59%	7%	15%	1%	6%	12%	3%	--	6%	9%
60% or more	7%	16%	1%	9%	19%	7%	--	1%	14%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

	General Industry	California	Arkansas/ Louisiana/ OK/Texas	Iowa/ Kansas/ Missouri	Minnesota	Michigan	New Jersey	New York	CT/Maine/ Mass/RI
INDIVIDUAL ANNUAL DEDUCTIBLE (option elected by the most employees)	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
No deductible (primarily HMOs)	18%	31%	17%	18%	44%	11%	15%	10%	30%
$100 or less	10%	9%	2%	2%	3%	25%	12%	9%	7%
$150	12%	16%	10%	10%	15%	8%	25%	5%	9%
$200	22%	12%	22%	38%	9%	34%	13%	14%	21%
$250	13%	11%	14%	8%	9%	11%	10%	12%	17%
$300 or more	14%	12%	24%	18%	14%	11%	10%	14%	9%
Varies by pay	10%	9%	8%	3%	3%	--	15%	36%	6%
Other (e.g., family deductible only)	1%	--	3%	3%	3%	--	--	--	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
INDIVIDUAL ANNUAL DEDUCTIBLE (option elected by the most employees--indemnity plan only)	(n = 562)	(n = 20)	(n = 51)	(n = 11)	(n = 14)	(n = 25)	(n = 46)	(n = 91)	(n = 44)
No deductible	3%	--	2%	--	--	4%	2%	1%	16%
$100 or less	14%	20%	2%	--	--	32%	15%	11%	11%
$150	13%	25%	14%	9%	29%	12%	28%	7%	9%
$200	25%	15%	33%	46%	14%	28%	15%	15%	30%
$250	14%	5%	10%	9%	14%	8%	13%	13%	18%
$300 or more	17%	35%	29%	36%	36%	16%	7%	14%	5%
Varies by pay	13%	--	6%	--	--	--	20%	39%	9%
Other (e.g., family deductible only)	1%	--	4%	--	7%	--	--	--	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

	General Industry	California	Arkansas/ Louisiana/ OK/Texas	Iowa/ Kansas/ Missouri	Minnesota	Michigan	New Jersey	New York	CT/Maine/ Mass/RI
AMOUNT OF ANNUAL OUT-OF-POCKET MAXIMUM (option elected by the most employees)	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
Less than $500	3%	1%	–	5%	3%	5%	3%	4%	3%
$500	4%	4%	–	5%	9%	17%	3%	4%	1%
$501 – $999	17%	10%	7%	23%	6%	11%	22%	11%	23%
$1,000	15%	17%	14%	13%	9%	19%	12%	8%	16%
$1,001 – $1,999	22%	20%	35%	18%	35%	11%	17%	16%	17%
$2,000	6%	13%	12%	5%	6%	–	3%	8%	2%
$2,001 – $4,999	6%	5%	13%	8%	6%	6%	5%	6%	2%
$5,000 or more	1%	2%	1%	3%	–	–	–	1%	–
Based on pay	10%	7%	7%	5%	3%	–	15%	31%	7%
Family limit only	4%	4%	4%	–	6%	14%	8%	1%	3%
Other (e.g., varies by years of service)	<1%	–	1%	–	–	3%	–	–	–
No out-of-pocket maximum	12%	17%	6%	15%	17%	14%	12%	10%	26%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
AMOUNTS OF LIFETIME PLAN MAXIMUMS	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
Less than $500,000	1%	1%	–	–	–	3%	5%	1%	4%
$500,000	6%	4%	6%	8%	6%	8%	3%	4%	4%
$500,001 – $999,999	5%	5%	5%	8%	6%	6%	5%	3%	–
$1,000,000	52%	52%	63%	59%	50%	44%	47%	44%	37%
More than $1,000,000	8%	13%	10%	2%	6%	8%	7%	6%	6%
No lifetime maximum	28%	25%	16%	23%	32%	31%	33%	42%	49%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

	General Industry	California	Arkansas/ Louisiana/ OK/Texas	Iowa/ Kansas/ Missouri	Minnesota	Michigan	New Jersey	New York	CT/Maine/ Mass/RI
INPATIENT LIMITS FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
No special limits	7%	2%	3%	3%	–	6%	20%	13%	4%
Limits for both mental health and chemical dependency	82%	90%	79%	89%	91%	78%	72%	77%	87%
Special limits for mental health only, none for chemical dependency	2%	1%	7%	3%	3%	2%	3%	3%	–
Special limits for chemical dependency only, none for mental health	6%	4%	9%	3%	3%	6%	3%	5%	7%
Other (e.g., limits for mental health, chemical dependency not covered)	2%	2%	2%	2%	–	8%	2%	2%	2%
Data not available	<1%	–	–	–	3%	–	–	–	–
Treatment not covered	<1%	1%	–	–	–	–	–	–	–
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
OUTPATIENT LIMITS FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
No special limits	4%	1%	5%	–	3%	3%	5%	5%	3%
Limits for both mental health and chemical dependency	87%	95%	86%	92%	82%	83%	80%	82%	86%
Special limits for mental health only, none for chemical dependency	5%	2%	5%	–	9%	8%	13%	5%	7%
Special limits for chemical dependency only, none for mental health	1%	–	1%	–	3%	–	–	1%	–
Other (e.g., limits for mental health, chemical dependency not covered)	3%	1%	3%	8%	3%	3%	2%	5%	4%
Treatment not covered	<1%	1%	–	–	–	3%	–	2%	–
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

	General Industry	California	Arkansas/ Louisiana/ OK/Texas	Iowa/ Kansas/ Missouri	Minnesota	Michigan	New Jersey	New York	CT/Maine/ Mass/RI
PRESCRIPTION DRUG COVERAGE	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
Comprehensive plan	45%	34%	46%	46%	50%	44%	50%	48%	39%
– with generic incentive	5%	3%	10%	5%	--	--	5%	5%	4%
– with mail order incentive	7%	6%	5%	5%	6%	11%	2%	13%	4%
– with combination of generic and mail order incentives	9%	8%	10%	5%	6%	8%	10%	11%	7%
Drug card plan (100% after co-pay)	7%	13%	4%	8%	12%	25%	10%	4%	6%
– with generic incentive	9%	16%	4%	13%	6%	3%	13%	4%	16%
– with mail order incentive	2%	2%	7%	2%	3%	3%	--	--	--
– with combination of generic and mail order incentives	6%	6%	6%	8%	--	--	3%	4%	10%
Depends on medical option selected	9%	11%	5%	8%	17%	6%	7%	10%	13%
Other	1%	1%	3%	--	--	--	--	1%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

	General Industry	California	Arkansas/ Louisiana/ OK/Texas	Iowa/ Kansas/ Missouri	Minnesota	Michigan	New Jersey	New York	CT/Maine/ Mass/RI
DENTAL PLAN PREVALENCE	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n= 70)
Have dental plan:									
– based on a percentage of charges	85%	93%	90%	81%	97%	86%	84%	74%	80%
– based on schedule	6%	3%	2%	5%	–	6%	3%	11%	12%
– based on a combination	3%	2%	1%	5%	–	–	5%	5%	4%
– depends on option selected	2%	1%	2%	3%	–	2%	3%	3%	1%
No plan–spending account only	3%	1%	4%	3%	3%	6%	5%	5%	2%
No plan–no spending account	1%	–	1%	3%	–	–	–	2%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
VISION PLAN PREVALENCE	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
Have vision plan	35%	60%	43%	46%	23%	31%	30%	21%	30%
Depends on medical option selected	1%	1%	1%	–	–	5%	–	2%	–
No plan–spending account only	44%	25%	29%	26%	59%	56%	47%	58%	56%
No plan–no spending account	20%	14%	27%	28%	18%	8%	23%	19%	14%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
HEARING PLAN PREVALENCE	(n = 1,034)	(n = 100)	(n = 102)	(n = 39)	(n = 34)	(n = 36)	(n = 60)	(n = 113)	(n = 70)
Have hearing plan	9%	8%	10%	13%	15%	22%	5%	8%	9%
Depends on medical option selected	1%	–	–	–	3%	–	–	1%	–
No plan–spending account only	57%	53%	47%	38%	62%	58%	62%	62%	70%
No plan–no spending account	33%	39%	43%	49%	20%	20%	33%	29%	21%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

ATTACHMENT B—HEWITT ASSOCIATES' DATA-BASED FINDINGS ON AVOIDABLE COSTS

In a very general sense, **roughly 40 percent of health care costs incurred by an individual employer may be avoidable.** We base this observation on having analyzed the experience of more than 200 major employers in the United States, representing the experience of 7 million individuals.

Provider Price

Provider price may account for up to 15–20 percent of inappropriate costs. The opportunity to control costs through more aggressive pricing arrangements can be as small as 3 percent or as high as 20 percent. Some carriers' managed care plans and Blue Cross and Blue Shield plans have negotiated very effective payment programs.

We realize that in today's environment, many of these pricing arrangements typically control costs simply by shifting the provider's costs to other payers not covered by such an arrangement. In a future environment where providers are subject to "pricing arrangements" for all payers, the cost savings in this area will have to come from pricing arrangements whereby the provider truly is cutting back on overall cost, instead of only shifting costs.

Utilization

Inappropriate testing and utilization of services may account for as much as 5–10 percent of the total cost. Price controls alone suggest to us that inappropriate utilization would be exacerbated. Managed care systems that truly track both inpatient and outpatient care by provider should be encouraged.

Lifestyle Management and Early Detection

Another source of inappropriate cost is tied to lack of early intervention and disease detection, potentially accounting for 5–15 percent of total health care charges. The availability of age-related and clinically supported preventive care benefits will help to reduce the risk of late detection. A primary care system should be considered in which physicians are accountable for managing health as well as illness and for communicating with their patients about the need for, and timing of, periodic exams. We caution, however, that it is not uncommon for 10–15 percent of the eligible work force to forgo their exams even if the exams are "free." Again, incentives to make employees both care for their own health and seek appropriate medical care should be encouraged.

Administrative Performance

Administrative inefficiencies can yield up to another 3–5 percent of unnecessary cost for larger employers (and a much higher percent of inappropriate cost for smaller employers). The current health care system supports as many claim forms, claim systems, utilization review approaches, and payment schedules as there are administrators. Simplification, uniformity, and streamlining are essential reform needs. The checks and balances applied to administrators are inadequate. Typically, it is only the larger employers who audit the accuracy and timeliness of their administrators. Smaller employers would benefit dramatically from having a Health Insurance Purchasing Cooperative or other source held accountable for auditing administrators. Just as the National Committee on Quality Assurance (NCQA) reviews processes that measure results and financial solvency ratings, we need a mechanism to ensure quality and accountability in the execution of financial and service transactions.

Employed Spouses

Coverage for employees' employed spouses who have access to other health insurance also may add more cost for employers:

- Duplicate coverage drains employers of investment and compensation opportunities, and the government loses taxable income from both employers and employees.
- Some employers bear the financial burden of being the community source for coverage if they have very low or no contribution for families (or if the employer's plan has more favorable benefit provisions).

If a decision is made to require employers to provide coverage for their own employees and dependents, cost-effective approaches to coordinating duplicate coverage should be addressed as well.

PREPARED STATEMENT OF PAINE SIPES-METZLER

Mr. Chairman and members of the Committee, I appreciate the opportunity to address you on the issue of whether Congress or a commission should develop the benefit package of health services for national health care reform.

My name is Paine Sipes-Metzler, and I am the Executive Director of the Oregon Health Services Commission, which was responsible for the development of the benefit package for the Oregon Health Plan. I am here today to recommend that a commission structure be utilized in the development of the benefit package recommendations and to offer some of the lessons that Oregon has learned from using a commission in this manner.

The government of the United States was created as a system of checks and balances to maintain an appropriate balance of power between the executive, legislative and judicial branches of government. In order to maintain the separation between the design of a basic health care benefit package and the financing of that basic benefit package, I would recommend that a commission be created. My premise for this recommendation is that Congress is responsible for balancing the resources necessary to create a healthy nation by the appropriate funding of educational, environmental, economic, public safety, and health care programs. These programs often offer competing but compelling reasons for additional funding which results in a reduction of funding in other areas. Congress, with its over arching vision, is the appropriate body to be responsible and accountable for the allocation or non-allocation of such resources, while allowing a separate board to develop the benefit package itself.

History has demonstrated that advancement of medicine and medical technology can occur rapidly. A commission offers the opportunity for a timely response through its dedication to a single purpose. The broad nature of issues that face Congress offer impediments to rapid responses, whereas a commission focused on health care and its advancements would be able to offer information and revisions as appropriate.

A commission would allow the benefit package to be regulated versus being written into statute. The actions required for changing statutes versus regulations vary significantly in time and effort. This is a critical issue from the state's perspective as the direction of the executive branch is to minimize statutory requirements which result in cumbersome waiver processes. A commission, based on legislative intent, would be able to ensure that the basic benefit concept is consistent in intent across states.

One benefit that the Oregon Legislature discovered from the use of a commission structure was the relief of political pressure for particular medical conditions. The development of a benefit package by the Commission focused the debate to a smaller area of services about which funding decisions were to be made.

I would like to focus on the strengths of a commission as a decision making body. Ideally, a commission would be an apolitical body that is focused on the goal of identifying a basic benefit package for the nation. A small group of people with different perspectives can offer a blend that is dedicated to improving the overall health of the nation. The success of the Oregon Health Plan has stemmed from the ability of the Health Services Commission to be apolitical, yet respond to various constituent concerns.

The selection of the commission members is a critical process. The commission should be of an odd number with no more than 15 members to ensure the ability to reach decisions in a timely manner. Membership should be selected from people who are active in the health care arena, representing both providers of health care and consumers and their health care advocates. Appointment to the commission could be by a sole source (e.g., the President) or equally between the branches of Congress and the Office of the President. Recognizing that these appointments will be political in nature, it is key that the individuals appointed understand the issues that surround health care benefits.

The limitation on the number of commission members encourages the use of smaller, technically competent panels or task forces for particular issues: This approach incorporates broader input, yet allows the decisions to remain with the commission using a uniform decision process. In Oregon, we found the use of task forces focused on special interests or populations allowed the development of responses to which all parties were satisfied.

Commissions are not without potential weaknesses. A commission may become fractionated by special interests or potential personal gain. Too many members may decrease the opportunity for the development of consensus and lead to splintered decision making. A commission may become preoccupied with the process that is being developed to achieve the goal rather than the goal itself.

Commissions have the ability to offer avenues to the public and respond to their concerns. This accessibility, while available in the legislative arena, is tempered by the fact that the public has to access a large number of the members of Congress to impact the decision. A small body is viewed as being more open and responsive to the public.

A key process that is required in the development of a benefit package is the blending of public values with scientific fact to ensure that the benefit package offers an acceptable outcome to the public. The commission structure and its use of small work groups promotes the opportunity for this unique identification of values to be integrated with fact.

A threat to a commission is that the commission may become a life to its own and, therefore, assume a political nature. Also, a commission could fail due to internal friction and lack of consensus on mandate. Lastly, adoption of activities that exceed the mandate of the commission can defeat the commission's effectiveness.

In summary, I recommend the use of a commission in the establishment of a basic benefit package for the following reasons: maintenance of a balance of power, the ability to respond timely to public concerns and changes in the health care field, its apolitical nature and an ability to achieve its goal. I would be glad to answer any questions that you may have.

PREPARED STATEMENT OF WILLIAM H. STRAUB

The Jackson Hole Group proposes that a standard benefit package defining the coverage available to all would be continuously amended by a National Health Board and approved by Congress and insulated from inordinate political interference and the influence of special interests.

A standard benefit plan is needed to:

(a) Facilitate the side-by-side comparison and choice of accountable health plans based on premium price and perceived quality. Multiple benefit plans obfuscate this process which is the very foundation of managed competition.

(b) Promote efficiency and reduce hassle through standardized claims forms and processes.

(c) Permit the determination over time of the cost and relative value of providing the various services covered by the standard benefit plan. This will be increasingly important as budgetary constraints impose tough choices regarding adding or deleting benefits.

(d) Facilitate the equitable application of policy particularly as regards tax exclusions and subsidies.

(e) Bring private and public programs together under a single system.

While a standard benefit plan is important, we should be careful to protect the public's clearly expressed value regarding choice of physician. We believe that this can be accomplished by requiring accountable health plans to offer an open-ended or point-of-service option (at increased cost). Plans could of course also offer a closed panel plan as well. Individuals would, of course, be free to purchase additional benefits at their own expense.

The standard benefit plan should be based on the scientific documentation of efficacy and relative cost-effectiveness. New technologies should be included in the benefit plan only after they have been shown to be more cost-effective than existing alternatives. Less effective technologies should be systematically excluded.

The determination of an initial standard benefit plan, along with the continual modifications that will be required, should be insulated from the political process whereby the influence of special interest groups rather than documented clinical effectiveness can largely determine which services are covered or excluded. For this reason, we would strongly favor that a national health board or commission appointed by the President, and approved by Congress, be charged with the responsibility for developing and modifying the standard benefit plan. Congress could then vote—up or down—the benefit plan or its modifications.

It remains important to stress, however, the need for a single, federally designated standard benefit plan. Many of the reasons previously identified rationalizing a standard plan argue strongly against leaving it to individual health plans or even states to develop benefit plans under broad federal guidelines. The goal should clearly be to develop a seamless and simple system. We should begin by defining an affordable standard benefit plan at the national level.

Finally, the public has a need and even a right to know what will be specifically included and excluded in any proposed standard benefit plan, and what it is likely

to cost them in terms of co-payments, deductibles, or new taxes. **This provides a true challenge to those offering plans to reform our health care system.**

Attachment.

MANAGED COMPETITION II

[A proposal from the Jackson Hole Group, March 1994]

INTRODUCTION

The managed competition proposals presented by the Jackson Hole Group in September 1991 have contributed significantly to the current debate on American health care reform. Critical elements of our earlier work—purchasing cooperatives, accountable health plans, outcomes information—are instrumental to most current state initiatives and many proposals for national legislation.

While these ideas have formed the basis of mainstream thinking about health care delivery Congress and the President have not yet been able to formulate a consensus strategy for ensuring universal coverage and effective cost containment. Each proposal for federal legislation seems stymied by its inability to predict the economic consequences of its implementation.

Changes of the magnitude envisaged under leading reform proposals have never been tried before, creating.tremendous uncertainty that threatens to undermine reform. No one can confidently estimate the costs associated with various proposals, how effectively different mandates will achieve universal coverage, the results of price controls or global budgets and whether they can be enforced, the lack of capacity that may result from a continued shortage of primary care practitioners or delays in accountable health plan (AHP) formation, how employers will use savings, the effects of increased consumer involvement in the decision-making processes, or the magnitude of savings that may be achieved by reducing the amount of ineffective care.

This level of uncertainty poses a serious risk to implementing effective reform. That risk, along with other lessons learned in actually applying managed competition, has caused us to revise selected parts of the original managed competition proposals. The underlying premise of Managed Competition II is that reform should adapt to observations and experience. This is exemplified by a common sense approach in which government health care Financing is always in balance, and is coupled to a step-by-step approach to reaching universal coverage. The original managed competition proposals continue to provide the basic framework for health care reform, as summarized in Table 1.

Managed Competition II presents three technical improvements to the managed competition model, including refinements in the design of Health Plan Stores (HelPS), increased protection for consumer choice of provider, and incentives for cost consciousness and healthy behavior. It also adds two critical policy initiatives to the original model: a balanced health security budget and a universal coverage program.

REFINEMENTS OF THE MANAGED COMPETITION MODEL

More and Smaller Health Plan Stores (HelPS)

As introduced in the original managed competition proposals, HelPS in a reformed system would act as sponsors for individuals and small employers, giving them the ability to pool risk, achieve economies of scale, and drive the competitive process through informed individual choice. HelPS should not be regulatory or price setting agencies and should not negotiate, or limit choice of AHPs. Rather they would offer an informed set of choices to help individuals to weigh personal priorities in health plan selection. If HelPS were allowed to negotiate (i.e., refuse to offer plans whose prices are too high), individual choice would be limited. In addition, an effectively functioning and competitive market would be undermined by concentrating too much purchasing power in a single entity.

While many private sector initiatives are proving effective in holding down health costs, especially purchasing efforts of large employers, the problems associated with the small group and individual markets have not improved and the need for HelPS remains. We initially proposed creation of a single exclusive HelPS in each geographic area to address the needs of the small group market. Recently, however, we have seen that concentration of purchasing power in monopoly HelPS provides a structural device that can be easily applied to constrain—rather than support—competitive markets.

We now propose a system of competing Health Plan Stores. States would be required to create a state sponsored Health Plan Store for pooling consumer purchas-

ing power, but multiple stores could be created to compete, providing that each meets the standards outlined below.

We appreciate the value of HelPS where participation would be voluntary, and have considered greater reliance on such structures. Experience has shown, however, that the small group market is easily fragmented into small, expensive groups that insurers avoid and small low cost groups that are easily insured. Such risk selection, and the associated cost shifts, remains the central problem which purchasing pools are intended to overcome and which will not be addressed by voluntary HelPS.

It therefore seems prudent to start with a system in which HelPS are the mandatory sponsors for the small group and individual markets, in that preferential tax treatment of health expenditures would be conditional on purchase of coverage through a licensed HelPS. This competing HelPS structure would still require special measures to ensure that the market is not undermined by adverse risk selection: Private sector organizations or associations could become licensed as—HelPS if they agreed to open enroll, offer all AHPs, cover entire HelPS regions, meet solvency standards, and conform to other HelPS standards including a prohibition against conflict of interest. AHPs would offer the same base community rate to all HelPS serving designated regions. HelPS would compete only on their administrative overhead (the cost of which would be added to premiums) and their customer service. Competing HelPS that negotiate premiums would undermine community rating in the small group market. In a system of competing HelPS, states would have to take on the additional responsibilities of dividing their territory into HelPS regions, and coordinating risk adjustment and standardized data collection. With this design, competing HelPS can still achieve the original HelPS goals, yet satisfy those that contend a need for significant reform of the small group and individual markets exists.

Rewards for Cost Conscious Consumers

Recent purchaser initiatives and state reforms have recognized the central role of consumer behavior (demand) in shaping successful reform. Any successful reform must include mechanisms for encouraging cost-sensitive utilization of health care services and healthy life style. A limit on the tax deductibility of health benefits remains the best way to instill cost-consciousness in health plan selection, control government expenditures, and raise revenue for low-income subsidies without increasing marginal tax rates. A revised tax code that addresses the concerns of the public while preserving cost conscious incentives would include:

- Extending full preferential health insurance tax treatment to all consumers that purchase coverage through the appropriate sponsor (i.e., large employer or Health Plan Store). A requirement to use the appropriate group sponsor would ensure that the risk of costly illness is fairly spread.
- Capping tax deductions and exclusions at the average of competitive AHP prices in the lowest quartile (25%) of AHP prices in an area (instead of at the level of the low-cost AHP). Consumers would be free to spend additional after-tax dollars on health care.
- Allowing those who choose an AHP priced below the tax cap to keep the difference in a tax-free health bonus account to be used to defray the costs of copayments, deductibles, and benefits not included in the standard benefits package or to supplement an individual retirement account.
- Allowing health plans to reward healthy lifestyles and behaviors with contributions to members' health bonus accounts.

Assuring Choice of Providers

The original managed competition proposals did not limit the type of health care delivery organizations that would compete in a reformed market. While we continue to support a marketplace which offers a wide variety of insurance and delivery models, we acknowledge public concern that consumer choice should not be restricted. For this reason, every sponsor should be required to offer at least one AHP with an out-of-plan (e.g., point-of-service) option, which allows enrollees to use non-AHP providers at increased cost. In the event that no AHP within a sponsor's region offers an out-of-plan option, all AHPs in that region would be required to do so.

UNIVERSAL COVERAGE UNDER MANAGED COMPETITION

Balanced Health security Budget

The original managed competition proposals focused on structural reforms and did not propose any specific strategy for financing universal coverage. However, as various financing schemes have been proposed in legislation, it has become clear that

the financing of health reform has implications for how structural aspects will interact. A managed competition approach to structural reform requires a managed competition approach to financing.

The United States needs to achieve a predictable and acceptable level of health care spending. In the current environment, spending can not be allowed to exceed available funding. A balanced health security budget would instill fiscal discipline into the health care system by guaranteeing that federal health expenditures do not grow faster than revenue and promoting an honest and explicit debate regarding these expenditures.

The balanced health security budget can be regarded as a ledger that (1) continuously matches federal revenues to expenses, (2) relates the benefits package to available financial resources, and (3) relates the benefits package to providers' demonstrated ability to improve function and well-being. Federal health spending covered by the balanced health security budget would include low income subsidies referred to as EquiP 1 and 2 (see below), Medicare, and the Federal Employee Health Benefits Program (FEHBP). The increases in lost tax revenue (tax expenditures) to the federal government, due to the preferential tax treatment of health expenditures, would also be counted as part of the balanced health security budget, thus helping to contain the growth in mandated private health security costs.

Under such a system, government health expenditures would be disbursed on a pay-as-you-go basis, and the health system would move toward universal coverage in carefully monitored stages. Each year, Congress and the HSC would adjust three elements of the health care financing system in order to achieve an annual health budget target. If projected expenditures exceed the rate of increase in the health budget target, the HSC would recommend to Congress either (1) an adjustment to the benefits package (the benefits package would be voted on in a manner similar to the military base closing procedure), or (2) a slowdown of the expansion in low-income subsidies. If Congress opted to not accept these recommendations, it would have to appropriate more money to achieve fiscal balance. While it might be preferable to have an explicitly earmarked health tax as the funding source for the balanced health security budget, it may be best to begin with existing sources of public health care funding. Ultimately, Congress must know what it is spending, who is covered for which services and the impact of benefits on the health of Americans.

Universal Access as a First Step to Universal Coverage

The best way to achieve universal coverage is through a competitive, premium-based system with adequate public subsidies for low income consumers, financed through progressive taxes. Such a system will require several years to be fully implemented and effective. Providers will need time to build high quality health plans, the government will need time to measure and evaluate progress and accumulate real savings to public programs from managed competition, and individuals will need time to understand and avail themselves of the reformed system. If we wish to build a national system that is sustainable, affordable, and integrated, then we must introduce significant policy elements carefully, in a way which permits us to fully understand their effects.

We must first establish a system in which all individuals have access to affordable coverage—universal access—as a first step towards universal coverage. Such a system would help those who need it most (i.e., the poorest individuals through subsidies and individuals and small employers through purchasing cooperatives and insurance reform), allow establishment of a truly competitive system, and permit a smooth transition to universal coverage by, say, 2002 if Congress passes comprehensive health reform in 1994.

Achieving universal coverage in a fiscally realistic manner will require that public programs are incorporated into a managed competition system and that a true universal access system is in place. A staging process follows:

STAGE—Equity Program, Part (EquiP 1): A government subsidy program for the current categorically needy (those receiving AFDC and SSI benefits) acute care portion of the Medicaid program that "equips them to obtain coverage.

Perhaps the greatest and most consistent challenge faced by state governments in recent years has been the dramatic increase in and unpredictability of costs in their Medicaid programs. While more states, like the private sector, now look to managed care as a means of tackling cost and quality problems, little more than 10% of Medicaid beneficiaries are in true managed care programs like HMOs. Reform must accelerate this process to instill Financial discipline and to realize predictability of costs and accountability for quality where neither have existed for some time. Furthermore, EquiP beneficiaries should have access to the same AHPs

and standard benefits as the general population to eliminate inequities in the health care system.

States would be responsible for the administration of their respective EquiP 1 programs, which would be fully funded as of the first year of reform and designed as follows:

- Because together they are generally regarded as above average risk and should be explicitly financed to ensure their costs are spread equally, the AFDC and SSI population would be maintained, at least initially, as a separate risk pool that is covered by AHPs.
- Each state, or contracted sponsor acting on behalf of the state, would base capitation rates for the EquiP 1 population on actuarially sound estimates of the average reasonable costs across AHPs of delivering a standard benefit package adjusted to the special needs of the AFDC and SSI population.
- The federal and state governments would jointly contribute 100% of the price of benefits for EquiP 1 beneficiaries. States would be required to maintain their current level of financial commitment to acute Medicaid and uncompensated care (current expenditures would be trended forward according to EquiP 1 experience). Thus, they would be at a relatively greater risk for their AFDC and SSI populations.
- Using a one-year voucher, the EquiP 1 eligible population could choose from among participating plans through their own EquiP 1 HelPS during the annual open enrollment period. For individuals who fail to select a health plan, the EquiP 1 HelPS would choose one for them.
- Once the EquiP 1 population had experience in AHPs and its risk could be predicted and adjusted with relative accuracy, it would be served by the local community HelPS, where the government would pay a competitive health status adjusted community rate on their behalf. Additional benefits that were not part of the initial standard benefits package available to the general population would be added as needed, funded jointly by states and the federal government and provided by AHPs.
- While personal costs for EquiP 1 beneficiaries should be mitigated so coverage is within their reach, they, like everyone else, should pay some portion of the cost of their care to instill a degree of cost-consciousness.

STAGE 2—Equity Program, Part 2 (EquiP 2): A government subsidy program for individuals below 200% of poverty, and those ineligible for EquiP 1 that "equips" them to obtain coverage.

The below-poverty uninsured population consist of 10.8 million individuals (28.1% of the uninsured), while the 100%–200% of poverty umnsured population represents an additional 12.5 million individuals (32.5% of the uninsured).[1] In addition to the subsidy available to everyone through the tax treatment of benefits and the contribution to health insurance by some employers, this population needs further subsidies to have meaningful access to the health system. EquiP 2 eligible individuals would receive subsidies in the form of vouchers, and would select their coverage through their local HelPS or large employer, depending upon employment status, thus minimizing the government's role in the program. EquiP 2 funding would be phased in as funds accrue to the government. The initial subsidization targets would be full subsidization into the low-cost plan for EquiP 2 eligible individuals below 100% of poverty, and a sliding scale of subsidies for beneficiaries between 100% and 200% of poverty.

Congress should appropriate sufficient funds to subsidize everyone in EquiP 2 by the year 2002. If these subsidies are effective, at least 95% of this population should be covered by then. If 95% of this population is not covered, Congress would need to expand the EquiP 2 subsidy program or proceed with some form of coverage mandate.

The present Medicaid program creates substantial disincentives for returning to work, since beneficiaries lose coverage after they cross the eligibility threshold. Combined with the loss of other low-income benefits such as the earned income tax credit, food stamps, and housing subsidies, this threshold represents a significant disincentive to earn more. While any scaling of health care subsidies would be an improvement over the current system, the pressing need to tackle welfare reform in conjunction with, or soon after health care reform, is apparent. To increase incentives for work, the increase in cost of health insurance associated with moving to a higher income bracket should be minimized. This can best be assured by phasing

[1] EBRI Analysis of the March 1993 Current Population Survey.

out public assistance for EquiP 2, at a gradual rate as income increases, and may require expansion of EquiP 2 beyond 200% of poverty.

STAGE 3—Guaranteeing Sustainable Universal Health Care Coverage

No system which provides for responsible financing can guarantee identical coverage for every U.S. resident. Just as definitions of "full employment" accommodate known structural deficiencies of the employment market, any working definition of "universal coverage" should allow for known political constraints (e.g., resistance to mandates) as well as unknown behavioral responses to reform (e.g., possible reluctance of wealthy to purchase insurance). Universal coverage might be defined as the point at which it can be verified that, say, 95% of the population are covered. (We are currently conducting some analysis that may allow us to be more precise in defining universal coverage.) As reform proceeds, the target percentage could be adjusted to reflect the point at which the additional cost of bringing individuals into the health security system through government means, such as a mandate or increased outreach, is too great for the public to accept. At some point it may make sense to adopt a policy that uniquely targets care for the residual percentage of uninsured, rather than devoting limited resources to the difficult and expensive task of pulling every individual into the general system of universal coverage.

To ensure that universal coverage is achieved within a reasonable timeframe, legislation should include a mandate (compulsory coverage) for the year 2002. If universal coverage, as defined by Congress has not been achieved by 2002, this measure would automatically force Congress to implement a mandate unless it took proactive measures to attain universal coverage by other means, such as increasing the scope of the Equity Program.

Congress should defer a decision on the nature of the mandate until 2002 to ensure that it is the appropriate measure. By then, much will have been gained from experience with a reformed system; broad low-income subsidies would be at or near full phase-in; competing AHPs would be functioning; group purchasing and health insurance reforms would have been in place for some time; and the residual uninsured population would likely be less significant in number and different in character than the presently uninsured population. Only with accurate information regarding the number and percentage of uninsured by employment status, income and demographic groups, geographic location, and health status can an informed decision be made regarding what type of compulsion, if necessary, would best lead to universal coverage. For example, if it is primarily low-income, unemployed individuals that remain uninsured it is unlikely that any form of mandate would be effective; instead, changes to the EquiP program would be required. On the other hand, if mostly wealthy, non-working individuals were uninsured, a free-rider tax would probably be the most effective way to achieve universal coverage. Finally, if large numbers of employed individuals were uninsured, an employer mandate might be the most appropriate. (Mandates are discussed further in the Appendix.)

Medicare

Medicare recipients should have the opportunity to receive the same universal standard benefits as the general population, with the same choice of providers and health plans. Equally, beneficiaries should be motivated to save money and pursue prevention and health maintenance measures. While reform of Medicare cannot be immediate since many beneficiaries value the present program, Medicare should ultimately resemble the rest of the health care system. The standard benefits package will be more comprehensive than current Medicare benefits and potentially eliminate the need for Medigap policies. While AHPs should be paid on a capitated basis for providing this enhanced benefits package to Medicare beneficiaries, cost-cutting measures proposed by Congress and implemented by HCFA could continue to control traditional Medicare expenditures. Medicare would start to be integrated into a managed competition environment as follows:

- The Medicare population would be maintained as a separate higher risk ad cost group. During an annual open enrollment period, regional Medicare HelPS would allow current Medicare beneficiaries to choose between traditional HCFA-administered Medicare with the present Medicare benefits, and competing AHPs offering the more comprehensive standard package, including prescription drugs Beneficiaries would have a greater choice of AHPs than present law permits, including AHPs that offer an out-of-plan provider option.
- For beneficiaries who choose a AHP, the federal government would make a defined contribution toward premiums. Under present law, Medicare risk-contracting HMOs are paid 95% of what HCFA estimates it would have paid for Medicare covered services had beneficiaries remained in the fee-for-service sector.

This system is fraught with problems, including ties to fee-for-service medicine and the geographic inequities in the distribution of Medicare reimbursement that penalizes regions of the country where health care expenditures are lower and better managed. Whatever future payment methodology is used, it should allow for a transition toward a system in which Medicare reimbursement is determined by competitive bidding ad consumer cost sensitivity (as in the private sector), and low cost regions are rewarded for their effectiveness. One such system would tie the government contribution to: the average of competitive AHP bids in the lowest quartile of AHP prices in a Medicare HelPS region, or the adjusted average per capita cost (AAPCC), whichever is lowest. Once the penetration of AHPs into the Medicare market exceeded a certain percentage, say, 50%, the tie to the AAPCC would be removed.

- Beneficiaries who choose an AHP would be responsible for paying the difference between the government contribution and the premium cost of their plan of choice. Present employer-sponsored retiree health benefits that pay for wrap-around coverage could be redirected to defray the difference between the government's defined contribution and an AHP's premium. Also, employers and retirees might agree to reconfigure retiree health benefits into a defined contribution, added to the government contribution, so that those who join AHPs receive the savings derived from their purchasing decisions.
- Beneficiaries that age into the Medicare program would be encouraged to continue obtaining standard coverage from AHPs.
- Eligible low income Medicare beneficiaries would continue to receive premium and cost-sharing assistance through EquiP 1 or 2.
- The present policies that impede HMOs from participation in the Medicare risk contracting program would be aggressively reduced with a significant shift toward policies that develop Medicare-oriented AHPs and encourage them to compete to serve beneficiaries.

As AHPs find ways to improve efficiency, they should be able to offer rates that are at or below the contribution set by government, even though they offer a richer standard benefits package. The opportunity to obtain more benefits at no additional, or only slightly higher cost, as well as continuity of care through primary care physicians, reduced paperwork, and the elimination of the need to purchase a Medigap policy, should motivate Medicare beneficiaries to join AHPs. However, present Medicare beneficiaries who place more value on the fee-for-service alternative could retain the opportunity to stay in the current system.

As AHPs succeed in lowering their costs below fee-for-service Medicare program costs, and more Medicare beneficiaries choose to enroll in AHPs, the federal government would achieve significant savings.

CONCLUSION

We can only achieve the required broad-based support for health care reform if we avoid rash, complex, and untested strategies. Federal reform measures must be sufficiently flexible to adapt to whatever new behaviors emerge in response to the changed health care environment. They must not preempt our ability to adjust key elements of the financing system as we learn more about what works. It would be foolhardy to guarantee universal delivery of a rich package of benefits only to find ourselves bankrupt before the decade expires, thereby undermining every American's ability to receive needed health care.

Managed Competition II is offered as a pragmatic approach to achieving universal coverage. If its concepts are ultimately selected as a template for reform, then several key elements of MC II are necessary if the integrity and effectiveness of the proposal are to be preserved:

(1) Staging of health care reform with the attainment of universal coverage by a specific date that allows a sufficient time interval for the development of a lasting health care system.

(2) Establishment of a health system based on consumers choosing between accountable health plans which compete on both price and quality.

(3) Promotion of cost, quality and health-conscious decisions by consumers.

(4) Obligatory purchasing of health plans through group sponsors including Health Plan Stores and large employers.

(5) A public program of equitable health care with the same incentives and benefit choices as the private sector.

(6) A balanced health security budget with pay-as-you-go financing of public health expenditures that prevents unfunded health care entitlements and instills fiscal responsibility.

It is our desire that Managed Competition II will expose to public and political scrutiny the interplay between funding, benefit levels, id health care effectiveness. It is designed to expedite access to affordable insurance coverage to every American, and provide a mechanism for sustaining universal coverage far into the future, regardless of shifts in the political mood, advances in technology, or changes in public needs. National health care reform can not hope to fix on a perfect financing formula in 1994; it must put in place, instead, prudent mechanisms for experimenting with, learning from, id responsibly managing our health care economy for the long term.

ACCOUNTABLE HEALTH PLANS (AHPs) - "The Providers"

AHPs are the "engines of reform" and would shift the emphasis in health care from disease and intervention to prevention and wellness. AHPs are organizations that:

- Both finance and deliver the full range of a nationally defined package of health benefits.
- Are accountable to the public for satisfaction of their members and the effect of their services on members' health.
- Comply with established solvency and underwriting standards, including community rating and guaranteed issue and renewal provisions.
- Adhere to uniform data reporting requirements as established by a Health Security Commission.

SPONSORS - "The Health Plan Store"

Large employers, government, and Health Plan Store (HelPS - formerly known as HPPCs, Health Alliances) would all act as sponsors that facilitate individual choice of health plan. In general the role of the sponsor is to:

- Provide information and incentives for individuals to choose among competing AHPs.
- Pool risk and achieve economies of scale in purchasing.
- Set rules to assure equitable coverage of all members of the sponsored group.

STANDARD BENEFITS - "The Measure of Universal Coverage"

A standard benefit package would:

- Provide a basis for defining services to be made universally available to all Americans, and put private and government programs on the same footing.
- Facilitate side-by-side comparison of AHPs (increasing elasticity of demand), and promote efficiency through standardized claim forms and issuing requirements.
- Be continuously amended by the HSC and approved by Congress through a process insulated from inordinate political interference.
- Be based on scientific documentation of efficacy, including cost-effectiveness.

THE HEALTH SECURITY COMMISSION (HSC) - "The Referee"

The HSC would be an independent federal agency to guide, oversee, and facilitate a transition to a new health system. HSC powers and responsibility would be explicitly limited in legislation to:

- Recommending a standard benefits package to Congress.
- Recommending measures to balance the health security budget (see below).
- Coordinating a standardized data reporting system.
- Setting standards for and licensing AHPs and HelPS.
- Disseminating information and making recommendations on risk adjustment.
- Entering into agreements with state governments to administer appropriate regulations.

Table 1: Core Elements of Managed Competition that Remain Unchanged

APPENDIX: DISCUSSION OF MANDATES

Combination of Mandates

A combination of employer and individual mandates, as outlined in Table A–1, best builds on the current employment-based system, ensuring that the 99% of com-

panies above the 100-person threshold currently offering coverage to their employees would continue to do so.

Employer Mandate for Large Employers

- All employers with more than 100 employees would have to offer a choice of AHPs offering the standard health benefits package to employees who work more than 30 hours per week, and their dependents. Employers would be required to make a defined contribution of a minimum of, say 50% of the price of the low cost plan to the health care premiums of their employees. To minimize employment effects, the mandated contribution requirement would be phased in over a period of time. A prorated contribution would be required for part-time workers who worked more than 1,000 hours per year and a payroll tax of X% would be paid for workers who work 1,000 hours or less.

- To assuage effects on employers near the HelPS threshold size, there would be a gradation of their financial obligation in accordance with firm size. These employers would not be relieved of their obligation to offer standard health care benefits.

Individual Mandate for Individuals and Small Employers

- Part-time workers (not otherwise covered) working 1,000 hours or less per annum for an employer with more than 100 employees and all individuals (not otherwise covered) not employed or those employed by firms with less than 100 employees would be obliged to purchase coverage through their local HelPS.

- At the direction of their employees, small employers would be required to make a monthly payroll deduction and send the amount to the appropriate HelPS.

To the extent that large businesses compete with small businesses in the same industry, employee compensation packages would differ, but since a mandate would exist in both sectors, total compensation in any individual firm should not be different. However, if employees do not recognize the trade-off between wages ad benefits, small employers would have a hiring advantage. A combination of employer and individual mandates would increase the incentives for firms to game the threshold by engaging in such actions as hiring 'temporary personnel and splitting companies into separate entities. However, this may be mitigated by phasing in the percentage requirement with firm size.

Low income is the major detect in access to health insurance, not size of firm in which one is employed. Therefore, for a combination approach to be equitable and efficient, the subsidization formula used must be consistent across mandate environments, and tied to income level (as in the EquiP program), not employment status. Individuals eligible for EquiP subsidization would use their vouchers either through their large employer or the HelPS to defray the cost of coverage. If, on the other hand, subsidies under the employer mandate were targeted at employers, as opposed to individuals, the employer mandate portion of the combined mandate would represent an inequitable and inefficient financing mechanism, and would result in the reallocation of labor on the basis of the subsidies available (so-called sorting).

The most expedient, efficient, and politically viable way to enforce the individual portion of the mandate would be through a free-rider tax. Individuals choosing not to purchase coverage would be required to pay a tax; Advantages of a free-rider tax are that it could be progressive and enforced by the IRS. The free-rider tax would be equal to a fixed amount plus a penalty that would be directly proportional to income. While such an enforcement strategy would not perfectly attain universal coverage, it would go a long way towards ending the free-rider problem while minimizing societal and economic dislocation.

Some proposals have embraced employer mandates and subsidies targeted at firms because they allow the government to shift some of the burden of public pro-

grams onto employers and create the perception that no one is paying the price. While fiscally attractive to the government, this type of mandate perpetuates cost-shifting, and causes the most economic dislocation because it effectively raises the minimum wage in many firms. To the extent that employers were unable to take the additional costs of health premiums out of wages, an employer mandate would cause some unemployment, especially in firms not currently offering coverage and in firms with low wage workers.

Individual Mandate

If individuals are targeted to receive low income subsidies to make those subsidies more explicit, efficient, and equitable, a mandate targeted at individuals makes sense as well (see Table A–2). An individual mandate could be easily and quickly implemented without disrupting present purchasing arrangements. It would satisfy those who believe the ultimate obligation to purchase health care should be on the individual, not the employer, id that health care coverage should be divorced from employment status.

- All individuals would be required to purchase coverage as of the date of implementation, or pay a free-rider tax.
- All employers, while not required to finance coverage, would be required to offer coverage, either through the HelPS if they have fewer than 100 employees, or directly for large employers.
- Voucher eligibility and preferential tax treatment would be contingent upon purchasing coverage through the appropriate sponsor.

The greatest potential disadvantage of an individual mandate is the risk that companies that are currently active, value-based health purchasers will cease these activities, and will perform the minimum duties necessary to fulfill the obligation to offer coverage. It is not possible to predict the extent of this behavior. However, business leaders suggest that competitive forces in the labor market may be sufficiently strong to maintain an active employer role, especially if there is a stipulation that predicates tax-preferred treatment of health expenditures on purchasing through the appropriate sponsor (the large employer for its employees). In addition, in a mandated environment, employees will value health purchasing that maximizes the wage portion of their compensation and secures quality health care. Employees of large firms without access to HelPs will look to their employers for purchasing expertise, since most employers purchase coverage for employees today If large employers prove to be inefficient purchasers, it would be possible for employees to pressure their employers to go to secondary purchasers such as purchasing coalitions, to purchase coverage.

Another potential serious disadvantage of an individual mandate is that upon passage, all individuals might demand access to HelPS. It is unlikely that Congress would have the political will to deny this. If the public then demanded that HelPS exercise greater control over the cost of health care, the result could be slow, but steady progression toward covering a great majority of the population through the HelPS—leading to regulation and possibly a single payer system. To some extent, competing HelPS should mitigate this danger.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

INTRODUCTION

Mr. Chairman and members of the Committee: Good day. My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore and Secretary for Federal Affairs of the American Academy of Ophthalmology.

On behalf of the Academy's 19,000 ophthalmologists—physicians who provide primary and comprehensive medical and surgical eye care, I am pleased to have this opportunity to present this statement.

The Academy supports the highest level of quality eye care afforded to each American. The organization's perspectives on quality of care can be found in its endorsed policies and positions, namely the Academy's Preferred Practice Patterns, which describe desirable practices to promote and provide for a more comprehensive quality of care.

However, the economic and political realities have pressed for an evaluation of what is considered a "basic" or more "minimal" level of care in order to assure financial access to coverage for every resident in this country. The difficulties in providing for the highest and most comprehensive level of health care for everyone have been pointed out by decisionmakers in the government and other public arenas. Society has acknowledged that it cannot provide all care to all the people all the time.

Therefore, to reach the goal of universal coverage, a level of care or benefits has been proposed. This is not an aspirational level of care; this is not a highly comprehensive level of care intended to discover all risks or signs of disease for each patient. This proposed level of care has been defined as a level of care that can be feasibly provided to all, with public funds covering all who cannot afford it on their own. For fitting this specific purpose, the Academy has developed this proposal for a core eye care benefit package to provide a broad range of eye care services.

This proposal provides for a more cost-effective solution than is provided for in the current, fragmented system because it specifies coverage of appropriate and effective care at periodic intervals as needed. It does not promote routine annual eye exams in the absence of risk factors, symptoms or signs of eye disease because they have not been proven cost-effective. Increased access to preventive care at appropriate intervals and timely, effective treatment should result in better health and reduce overall costs of disease treatment.

BACKGROUND

Eye care is an integral component of health care and contributes to the well-being and daily functioning of American citizens. Vision is the principal pathway for learning for the young, and primary means of communication for adults. Vision is vital for acquiring skills and maintaining optimal performance in today's high technology society.

Disorders and diseases of the visual system are widely prevalent. More than 100 million Americans have or could benefit from spectacles, and one-third of all Americans have a medical or surgical disease of the eye and visual system. Nearly 11.5 million persons in the U.S. suffer from vision impairment to some degree, and half a million are unable to lead normal, productive lives. There is still a great need for eye care services. It is estimated that approximately half of all cases of blindness could be prevented if patients were to receive current treatment in a timely manner.

Tremendous strides have been made through ophthalmologic advances in the detection and treatment of eye disease. Advances in the treatment of cataracts, diabetic retinopathy and glaucoma have enabled many millions of Americans to retain visual function and lead productive lives. Treatments that prevent visual loss and disability produce significant savings to society. For example, early detection and

treatment of diabetic retinopathy is estimated to cost $966 a year for saving the sight of each person, compared with an average annual cost of $6,900 in social security disability payments, and if the federal government were to pay all the costs of an early screening and treatment program, the net annual savings would be $103.5 million.

Ophthalmology, as part of the medical profession, is dedicated to the basic purpose of patient care of enhancing the health of an individual person and society through early diagnosis and timely treatment of ocular and systemic disease processes. The ophthalmologist views each patient as a complex, integrated human being with other medical conditions, with the ultimate goal of promotion of health of the whole person.

Core eye care benefits should be considered together with other medical care benefits because of the close interrelationship between the eye and other organ systems. The eye is a microcosm of the whole body and inextricably affected by systemic disease processes. Signs of a systemic disease might be first detected during an eye examination. Diabetes, hypertension, AIDS, many brain tumors or disorders of the brain, hematological or immunological disorders can often be detected first through ocular signs. Medications prescribed for systemic diseases could have untoward and undesirable side effects on the eye and visual system, and vice versa. For example, medications commonly used to treat glaucoma such as beta-blockers have effects on the cardiac and pulmonary systems. In the treatment of immune diseases or respiratory diseases, the use of steroids might induce eye diseases such as cataracts or glaucoma.

DEFINITION OF CORE EYE CARE BENEFIT PACKAGE

In order to ensure every American equal opportunity to good vision and eye health, core eye care services should be made accessible for all, regardless of his/her ability to pay. The core eye care benefit package includes the following:

For healthy patients with no known eye disease:

(1) preventive vision screenings and eye health screenings for children;
(2) refractive examinations for children and adults as needed;
(3) preventive basic eye evaluations for adults;
(4) periodic comprehensive eye examinations for children and adults in general population; and
(5) periodic comprehensive eye examinations for groups at high (statistically greater) risk for developing eye disease.

For patients with eye disease (children and adults):

(1) periodic comprehensive medical eye examinations and other medical eye exams, including consultant and referral services;
(2) medical testing and diagnostic services, including laboratory and imaging services;
(3) medical treatment of eye diseases on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services;
(4) surgical evaluation and treatment on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services; and
(5) follow-up and monitoring.

FUNDAMENTAL SERVICES

The fundamental services provided in the core benefit package are described as:

(1) vision screening and eye health screening;
(2) a refraction;
(3) a basic eye evaluation;
(4) a comprehensive eye examination; and
(5) medical and surgical services.

Patient education is an essential component of preventive services to provide patients with information on how to avoid eye injuries, reduce risk factors for disease, develop healthier behaviors and promote the benefits of early disease detection. For care to be optimal, patients need to be made aware of the importance and benefits of early detection and treatment of eye diseases and conditions, and take more responsibility for their own health.

There are two kinds of eye screenings. The **vision screening** consists of a testing of distance Snellen acuity with the patient utilizing the current spectacle correction (if any) for the purpose of detecting visual problems. It is not a truly diagnostic procedure and cannot detect all visual problems nor identify their causes. The screening is usually performed efficiently, as accurately as possible and at the lowest cost

in order to serve the general population. It is most useful on a periodic basis for detecting visual problems in the pre-school and school-age population. An **eye health screening** consists of a vision screening with a general, brief history of any symptoms or previous eye diseases, and an abbreviated evaluation of the pupil, ocular alignment and motility, and the fundus. This does not require dilation of the pupil and could involve an ophthalmoscopic examination and intraocular pressure measurement. This is useful in a pediatric population where risks of developing eye disease are fairly low, but where more common eye conditions can be screened through simple testing (strabismus and amblyopia). These screenings can be performed by a variety of providers.

A **basic eye evaluation** consists of a general history of the patient, complete history of eye symptoms or previous eye diseases and an evaluation of the gross anatomic and physiologic status of the eye. This would include a slit-lamp examination and ophthalmoscopic examination, and may or may not include dilation of the pupil. Testing of extraocular muscle motility, including a determination of visual acuity, measurement of intraocular pressure and a pupillary evaluation would be included. The basic eye evaluation should be performed by a qualified eye professional defined as one having the competence to take and evaluate an appropriate systemic and eye history, to recognize risk factors, indications by family history and systemic conditions, signs and symptoms of eye disease and conditions and to perform and interpret the components of the evaluation.

A **comprehensive eye examination** is a more thorough medical exam, and consists of three major components: medical history, history of any eye conditions, and evaluation of anatomic status and physiologic function. A thorough history collects demographic data, past history, other systemic conditions, use of systemic and topical medications and other relevant information. During this process, information about the patient's general health status and any systemic symptoms are evaluated and interpreted. The evaluation of the anatomic status of the eye focuses on three major areas: lids, lashes, lacrimal apparatus, orbit and other pertinent features; anterior segment, including the conjunctiva, sclera, cornea, anterior chamber, iris, lens and posterior chamber; and posterior segment, including the retina, vitreous, uvea, vessels and optic nerve. Examination of the posterior segment is best performed and usually done through a dilated pupil and examination with a direct and indirect ophthalmoscope. The evaluation of physiologic function includes, but is not limited to the following: measurement of visual acuity with present correction, measurement of best corrected visual acuity obtained by refraction, testing of ocular alignment and extraocular muscle motility, evaluation of pupillary status and measurement of intraocular pressure. An ophthalmologist, by virtue of his or her M.D. or D.O. training, has the level of skills and knowledge to assess and interpret general medical history and examination, ocular and systemic signs and symptoms related to the patient's condition, and the competence to perform and evaluate this examination.

A **refraction** or examination specifically directed towards prescription of corrective lenses is defined as a fundamental service for the core benefits and should be covered when indicated by a change in the patient's visual function. A diagnostic refraction is an integral part of a comprehensive eye examination that is indicated at appropriate intervals throughout a patient's lifetime. A refractive exam consists of a quantitative measurement that yields the data necessary to determine the best visual acuity with corrective lenses and to prescribe these lenses. A refraction constitutes a significant component of eye care to the public. Because it is nearly universally applied to the general healthy population and its costs can be well-quantified, it is not normally considered as an insurable risk. For example, under the Medicare program, refractions have not been routinely covered, and the Academy supports this decision. However, as health care reform seeks to develop a more comprehensive health benefit package, and as refraction is an important component of total eye care and valued by the American public, it is included in this core eye care benefit package. A refraction is not recommended routinely in the absence of visual symptoms and is not necessarily required more often than outlined in the program of basic and comprehensive examinations. To assure good vision and eye health, any patient who perceives that his or her vision has decreased should be evaluated. These services would not necessarily include any other screening or basic examination.

Medical and surgical services include ordering and performing of appropriate supportive testing, prescription of pharmacologic treatment, performance of other medical procedures, evaluation for surgical treatment, performance of surgical procedures, including laser surgery, delivery of post-operative care, follow-up and monitoring of patients with eye diseases. An ophthalmologist, by virtue of broad medical expertise, schooling in diagnostic abilities and clinical decisionmaking in general pa-

tient management, and specialized medical study of the visual system and training in the broad range of treatment methods, should perform medical and surgical services for the diagnosis and treatment of eye diseases.

ELEMENTS OF THE PACKAGE

The following briefly describes the schedule for periodic preventive eye examinations for children, adults and high-risk groups with more detailed tables available upon request.

Children:

For all children, early comprehensive eye examinations are important to detect or evaluate inborn or congenital eye abnormalities and those associated with prematurity. These include fixation preference, ocular misalignment or ocular diseases leading to amblyopia, cataracts, glaucoma or tumor. There should be an eye health screening when the baby is in the nursery and at six months of age. There should be an eye health screening at approximately 3 years and 5 years of age. An initial comprehensive eye examination should be performed when a child is between three to and 5 years of age. Between 7 to 18 years, children should have an eye health screening, and receive vision screenings at ages 8, 12, 14 and 18 years.

Adults:

For the general adult population without symptoms or other indications between the ages of 19 and 39 years, an initial comprehensive eye examination is indicated. In the absence of risk factors, symptoms or other indications, these healthy adults do not require routine annual evaluations. African Americans between the ages of 20–39 years old require a comprehensive eye examination every 3 years, because of a higher incidence and more aggressive course of glaucoma. All adults aged 40 to 64 years old should have a basic eye evaluation every 2 years, and adults over 65 years old should have a basic eye evaluation every year. All adults should have a comprehensive eye examination once between the ages of 40 and 60 years and once around the age of 65 years. A comprehensive eye examination should also be performed when indicated by risk factors, signs or symptoms.

High-Risk Groups:

For patients, both adult and children, at high (statistically greater) risk to develop eye diseases, such as having a systemic disease associated with eye problems, use of systemic medications with ocular complications, history of risks of eye injury due to vocation, or family history of eye disease, the frequency and intensity of examination should be increased to detect the onset of vision-threatening diseases as promptly as possible. Comprehensive eye examinations should be provided at appropriate intervals, with frequency depending on the risks encountered, the patient's condition and likelihood for detecting onset of disease as determined by clinical judgment.

Patients with Eye Symptoms and Diseases:

Patients who have signs or symptoms may first be identified through an initial screening or eye health screening. After a screening, children warrant a comprehensive eye examination if they have abnormalities upon exam; signs or symptoms of eye problems by history; multiple health problems, systemic diseases or use of medications associated with eye disease; relevant family history; or health and developmental problems that make screening difficult.

The following eye symptoms or systemic diseases warrant referral for a prompt comprehensive eye examination: failure to achieve normal visual acuity in either eye unless cause of impairment has been medically confirmed by prior examination and visual acuity is stabilized, significant eye injury or eye pain, flashes of light, recent onset of floaters, halos, transient dimming or distortion of vision, obscured vision, loss of vision or pain in the eye, lids or orbits, double vision or excessive tearing, loss of any part of the visual field, abnormalities in the transparent media of the eye or in the fundus or optic nerve head; tumor or swelling of eyelids or orbit, protrusion of one or both eyes, inflammation of lids, conjunctiva or globe, with or without discharge, strabismus, abnormal intra-ocular pressure, diabetes mellitus, eye abnormalities associated with thyroid disease, HIV-positive patients with ocular symptoms and all patients with AIDS.

Individuals with acute eye symptoms should have a prompt comprehensive eye examination and appropriate follow-up visits. For patients with defined eye diseases or decreased visual function, appropriate medical and surgical services should be

provided for diagnosis and treatment of their conditions. These services should meet the test of medical necessity and reasonable provision of care, based on current practice guidelines, and should be provided by qualified professionals. Patients with chronic eye diseases should be evaluated periodically, with the frequency of visits depending on the severity of the condition, the response to therapy and the potential for disease progression.

CONCLUSION

In closing, the Academy believes that access to appropriate and timely eye care, as provided for in this benefit package, will result in better health for Americans and reduced overall costs for disease treatment. We recommend the use of the Core Eye Care Benefit Package to ensure that the resources allocated for eye care under any health system reform proposal are used effectively and cost-efficiently.

We thank the members of the Committee for their attention to this issue and we appreciate the opportunity to present this statement to you.

Statement of the American Association of Oral and Maxillofacial Surgeons

I. INTRODUCTION

The American Association of Oral and Maxillofacial Surgeons (AAOMS) appreciates the opportunity to submit this statement for the record and convey our views on the Health Security Act of 1993.

The AAOMS, founded in 1918, represents more than 6,000 oral and maxillofacial surgeons, and is one of the oldest surgical specialty organizations in the United States. Oral and maxillofacial surgery (OMS) is the surgical specialty of dentistry that deals with the diagnosis, and surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

An oral and maxillofacial surgeon is a dental school graduate who has completed a postgraduate hospital residency in an accredited oral and maxillofacial surgery training program, including a core surgical year. This year of comprised of rotations in internal medicine, general surgery and anesthesia services. In addition, she or he completes a minimum of 30 months of surgical halting focused in the maxillofacial region. Oral and Maxillofacial surgeons heat a significant number of patients in an outpatient setting. Their expertise in this area includes in-depth knowledge of ambulatory general anesthesia and sedation, gained through residency hating and an in-office evaluation program required by the specialty. The AAOMS is dedicated to continuing education, clinical research, and quality of patient care in the field of oral and maxillofacial surgery.

The AAOMS has been progressive in its endeavors to advance the specialty of oral and maxillofacial surgery. Through the establishment of the Oral and Maxillofacial Surgery Foundation, the specialty has committed itself to continuing improvement of patient care through support of education and research. The OMS has raised more than $5.1 million for the Foundation's Endowed Research Fund to ensure the long-term availability of funding for research in oral and maxillofacial surgery. In the past two years alone, the OMS has awarded $380,000 to research applicants.

Furthermore, the AAOMS has been in the forefront of the health care field as one of the first specialties to develop parameters of care. The establishment of these parameters provides a means to assess the appropriateness and quality of treatment to patients heated by oral and maxillofacial surgeons. This represents the strong commitment to patient care and accountability of the specialty of oral and maxillofacial surgery.

The AAOMS was one of the eighteen specialties examined in Phase I of the Harvard Resource-Based Relative Value Study. Since then the AAOMS has worked closely with Harvard, the Physician Payment Review Commission and the Health Care Financing Administration to refine the Medicare payment system.

II. AAOMS POSITION AND VIEWS ON HEALTH CARE REFORM

In viewing the development of health care policy, the AAOMS has identified some issues with respect to health care reform legislation of critical concern to oral and maxillofacial surgeons.

The most important issue for any health care provider is to assure that patients have access to care, and that providers have the ability to provide it as well and as efficiently as possible. With that in mind, our central concern is that any health care reform plant not permit discrimination against oral and maxillofacial surgeons because of their academic degrees in dentistry.

Degree of provider discrimination occurs when a licensed and highly trained oral surgeon is subjected to diminution of authority, refusal of reimbursement, or restriction in providing services solely on the basis on his or her academic degree. These practices by third parties are detrimental to the effective delivery of health care. This can result in preventing the public from receiving care from the health care provider most experienced and skilled in handling the needed procedures. This ultimately translates to increased costs to the consumer and a lower quality of health care.

Degree Recognition

Oral and maxillofacial surgeons have a long history of providing care for trauma. Yet, over the years, other oral and maxillofacial surgeons have encountered health plans that limit our participation or reimbursement because we have a dental degree and not a medical degree. For instance, there are plans which cover treatment for a fractured jaw, but only when the services are provided by an M.D., even though it is a procedure for which we are trained and licensed.

Oral and maxillofacial surgeons have also been discriminated against by plans that permit a non-M.D., such as an oral and maxillofacial surgeon, to provide treatment, but then reimburses the provider at a differing rate because of their academic degree. This arbitrary distinction has nothing to do with the provider's ability or experience and therefore should not be permitted. We believe that no health care reform legislation should permit managed care plans to discriminate against health care providers, in the areas of participation or reimbursement, because they hold or do not hold one type of academic degree. This problem is widely recognized at the state level, where 46 states have enacted legislation prohibiting discrimination based on the academic degree of the provider.

This concept of equality between oral and maxillofacial surgeons and M.D.s, and prohibiting degree of provider discrimination is endorsed not only by the AAOMS, but by the Medicaid and Medicare systems with their adoption of a physician definition that includes oral and maxillofacial surgeons, and by 46 states. In implementing the Resource Based Relative Value Scale in the Medicare payment system, the 1989 Omnibus Budget Reconciliation Act dictated equal payment for the same service regardless of provider academic degree. That mandate has been specifically and repeatedly endorsed by Congress, the Physician Payment Review Commission, the Health Care Financing Administration and Harvard during the past five years.

Degree of Provider Protection and The Health Security Act

As proposed, the Health Security Act recognizes the importance of prohibiting degree of provider discrimination. Its definition of health care providers and health professional services encompasses individuals legally authorized by states to deliver health care services. By not distinguishing between M.D.'s and other health care providers, the Act would prohibit some forms of discrimination. In addition, the Act prohibits health alliances and health care plans from discrimination against the mix or anticipated need for health professionals.

However, by not explicitly prohibiting degree of provider discrimination, the Administration's proposal does not adequately address our concerns.

We believe the Health Security Act of 1993 should prohibit state, regional or corporate health alliances or other plans from discriminating in employment, contracting, participation, reimbursement, or indemnification against a doctor of dental surgery or of dental medicine who is acting within the scope of the dentist's professional license under applicable State law, solely based on the academic degree of the provider.

This language does not require a plan to reimburse oral surgeons or any type or category of provider. Moreover, the language would not prohibit a plan from limiting the number and type of health care providers, and would not require that any *additional* or *related* services by covered. Rather, the language merely prohibits a plan that already provides coverage for certain services (*e.g.* surgery for a jaw fracture as a result of an automobile accident) from discriminating against an oral or maxillofacial surgeon solely because he or she is a dentist who is licensed to perform such services and not a medical doctor.

Hospitalization of Patients

As oral and maxillofacial surgeons, we, like other doctors, have patients who vary in their physical condition, medical history and pain tolerance. To provide our patients with the highest quality of care, the least amount of risk or discomfort, we must have the authority to hospitalize patients when their medical condition so dictates. This authority currently exists in virtually all U.S. hospitals accredited by the Joint Commission on the Accreditation of Health care Organizations (JCAHO).

We believe that the needs of the patient and the experience, training, and ability of the health care provider should be the critical factors that determine plan participation and reimbursement policies. Our specialty is unique in its training curriculum and its scope. We bridge the disciplines of dentistry and medicine. Our scope of practice encompasses dental and medical procedures, and although the distinction between which procedures fall under what heading is at times clear cut, at times there exists a significant overlap. Oral and maxillofacial surgeons complete dental school, at least an additional four years of residency, and have clinical experience in medicine, surgery and anesthesia.

As surgeons, nearly all of us work in a hospital setting, and are subject to each hospital credential committee's high and stringent standards that are based on the JCAHO. Education, training, experience and quality assurance ensure that patients receive the best care from the best qualified individuals.

III. COVERAGE OF ORAL AND MAXILLOFACIAL SURGERY SERVICES

Obviously, the issue of cost will likely determine what is included in the final version of any health care reform legislation. At this time, the AAOMS does not have sufficient information on the parameters of the Health Security Acts benefit plan to provide the Subcommittee with specific recommendations on which oral and maxillofacial surgery procedures should be covered. However, we have reviewed the provisions of the Administration's proposal and believe the following critical procedures performed by oral and maxillofacial surgeons should be considered as included in the plan's comprehensive benefit package:

1. Anesthesia

The specialty of OMS pioneered the delivery of outpatient anesthesia, over forty years ago. Through a continuous process of refinement of existing techniques and the adoption of new procedures, fully 75 percent of OMS care is now delivered in the outpatient setting. Sedation and general anesthesia form the cornerstone of our ability to provide this public service. We believe that this medical service should be included in any basic health care package.

2. Birth Defects, Growth, and Development Problems

We subscribe to the notion that there is little as important as providing optimum care to the young among us. We therefore believe that any congenital defects must be addressed as expertly and expeditiously as possible so that all can become fully participatory in our society.

An example of some of these defects are cleft lip and/or palate, facial clefts, hyperplasia, hypoplasia, aplasia, neoplasia, hypertelorism, dystopia, Crouzon's syndrome, Apert's syndrome, Treacher-Collins syndrome, or identified by other descriptive terminology.

Similarly, we adhere to the belief that those among us who suffer growth and development problems resulting in not just stunted physical development be granted the same opportunity of care.

Our ability to correct the function of the facial skeleton as well as the correction of hard and soft tissue deficiencies. secondary to congenital and acquired defects should be an integral part of any basic health plan.

3. Trauma

Trauma remains a major health and social issue in the United States. Every year, hundreds of thousands of people of all ages sustain facial injuries from automobile and bicycle accidents, athletic activities, or altercations. Many of these injuries are maxillofacial fractures—fractures of the lower jaw, upper jaw, palate, cheek bones, nasal bones, bones surrounding the eyes, or combinations of these types of facial fractures.

Our involvement in facial trauma is all inclusive. Such facial trauma all too often causes significant oral disruption resulting at times in serious interference with one's ability to masticate, swallow, breath, smell and see. Treatment of these patients often requires hospitalization and the skills of professionals trained in trauma management. The patient may have chronic pain, and those with extensive residual defects frequently become emotionally impaired. Due to tissue loss, subsequent reconstructive procedures are often necessary to allow the patient to re-enter society expeditiously and fully functional.

The principles of treatment of a facial fracture are the same as for a fractured arm or leg. The parts of the bone must be aligned (reduced) and held in position (fixed, stabilized) long enough for healing to occur. This may require six weeks or more, depending upon the patient's age and the complexity of the fractures. When

fractures are extensive, multiple incisions to expose bones in order to employ a combination of reduction and fixation techniques (e.g., wiring or plating) may be needed.

4. Pathology

Pathology of the maxillofacial region includes tumors, both malignant and benign, and infections of odontogenic (dental) and non-odontogenic origin. Pathology also includes disorders of the temporomandibular joint, which often result in severe pain and dysfunction. The disabilities resulting from a dysfunction of this joint are no different than those emanating from joints anywhere else in the body. Again, the reconstruction of any anatomical disruption resulting in dysfunction is an indivisible part of therapy.

Finally, we endorse the view that reconstruction of deformities or disease conditions resulting from prior surgery should be treated the same as other surgical to or therapeutic procedures.

IV. CONCLUSION

Oral and maxillofacial surgeons also perform other outpatient dental procedures, which are normally covered under dental insurance policies, and are not included in our recommendations for health care reform.

The AAOMS is currently evaluating the development of a more specific list of prioritized OMS services. Such a list could be relevant to the determination of which OMS procedures should be included in a standard benefit package. As Congress proceeds in its deliberations of any health care reform legislation, including the Health Security Act of 1993, the AAOMS will be available to discuss the specific details of the health care plan with the members of the Senate Finance Committee.

PHYSICIAN PAYMENT REVIEW COMMISSION

Annual Report to Congress 1990

CHAPTER 9

PAYMENT TO LIMITED LICENSE PRACTITIONERS

Under the Omnibus Budget Reconciliation Act of 1989, Medicare will pay for physicians' services under a fee schedule based on resource costs. This fee schedule will apply not only to doctors of medicine (MDs) and osteopathy (DOs) but to limited license practitioners (LLPs) defined as "physicians" under the Medicare statute, specifically, as:

- doctors of dental (oral) surgery or dental medicine,
- doctors of podiatric medicine,
- doctors of optometry, and
- chiropractors meeting certain educational and licensing standards.

Because Congress has resolved the issue of whether limited license practitioners should be incorporated into the fee schedule, this chapter reflects the Commission's thinking on how that should be accomplished. The chapter begins with a review of current Medicare policies affecting payment to LLPs. It then describes the practice characteristics and professional training for each of the four types of practitioners and analyzes Medicare charge data for their services. The chapter concludes with a discussion of the Commission's recommendations for payment of LLPs under the Medicare Fee Schedule. Although other concerns about Medicare policy related to LLPs, such as service coverage and competency to perform specific services, have been raised, this chapter focuses on payment.[1]

RECOMMENDATIONS

The principle stated in the Commission's 1989 report that physicians should be paid the same when the service is the same should apply to all practitioners defined as physicians under the Medicare statute.

[1] Other issues related to limited license practitioners, including Volume Performance Standards and practice guidelines, are discussed in Chapter 11.

Oral and Maxillofacial Surgeons

While dental services are not covered by Medicare,[5] doctors of dental surgery or dental medicine may receive payment for other services. These include surgery related to the jaw or contiguous structures, reduction of jaw or facial bone fractures, dental examinations necessary to detect infections prior to surgery, treatment of oral infections, and interpretation of diagnostic X-rays in connection with other covered services.

[5] Medicare defines dental services as the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth.

Dentists specializing in oral and maxillofacial surgery receive four years of residency training beyond the four-year post-baccalaureate D.D.S. degree. The curriculum includes instruction in basic sciences and physical diagnosis as well as rotations in anesthesia, surgery, and internal medicine.

Services provided by oral surgeons accounted for only $11 million, or 0.05 percent, of Part B allowed charges for physicians' services in 1987. While their services account for a substantial proportion of allowed charges for a small set of procedure codes (Table 9-4), this set of procedure codes does not account for a substantial proportion of charges by oral surgeons to Medicare beneficiaries. The top 90 percent of oral surgery allowed charges is distributed among 187 codes (Table 9-5).[6]

Oral surgeons bill for many of the same codes as otolaryngologists, general and plastic surgeons, and in some cases, radiologists (Table 9-4). Some variation exists in average allowed charges across these specialties (Table 9-6). These figures should be viewed with caution, however, due to the small number of services provided by each specialty for a given procedure code.

RECOMMENDATION

The principle stated in the Commission's 1989 report that physicians should be paid the same when the service is the same should apply to all practitioners defined as physicians under the Medicare statute.

Because oral and maxillofacial surgeons were surveyed by Hsiao in his Phase I study, the Commission already has resource-based relative values for their services. In addition, cross-specialty links have been established that permit comparison of intraservice work between oral and maxillofacial surgeons and MD specialties. One family of oral surgery codes, irrigation and exploration of maxillary sinuses (CPT codes 31000-31033), was included in the Commission's reference fee schedule submitted to the Congress in late 1989.[8]

RECOMMENDATION

Oral and maxillofacial surgeons should be paid under the Medicare Fee Schedule, using the same relative values and conversion factors as applied to doctors of medicine and osteopathy.

Information about resource costs for services billed by LLPs under the same procedure codes as those used by MDs and DOs could be used to assign relative values for some

[8] See Physician Payment Review Commission, *Services and Procedures for Initial Transition Step to a Medicare Fee Schedule*, prepared at the request of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, September 21, 1989.

STATEMENT OF THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services which support total health through the promotion of optimal oral health.

ADHA commends Congress for making reform of the nation's health care delivery system one of its highest domestic priorities. We are committed to participating in this process to ensure universal access to cost-effective quality health care, including, *at a minimum,* preventive oral health services. Oral health *is* a part of total health and the oral health care delivery system requires reform along with the medical care delivery system.

ADHA is pleased that the Health Security Act proposed by President Clinton includes preventive and primary dental care for children as well as emergency care for both children and adults. However, in light of the proven cost-effectiveness of preventive oral health care—where each $1 spent yields $8–$50 in savings—ADHA feels strongly that preventive and other basic oral health care benefits should be provided to adults from the outset. As currently written, the Clinton plan would phase in additional dental benefits for adults by the year 2001.

ADHA has joined the Coalition for Oral Health, which includes approximately twenty-five national oral health organizations, to press for the inclusion of cost-effective oral health benefits in health care reform legislation. The Coalition, using U.S. Public Health Service data, has developed a preventive and primary oral health package for children and adults which would cost a modest **less than $10 per person per month.** *This package would include: preventive services consisting of a professional oral health assessment, dental sealants, professionally-applied topical fluoride, an annual dental cleaning (oral prophylaxis), and fluoride supplements; acute, emergency dental services; early intervention services (to maintain and restore function) including restorative services and periodontal maintenance services; and certain accommodations for persons with disabilities.*

ACCESS TO ORAL HEALTH CARE

The Institute of Medicine estimates that fifty percent of Americans do not receive regular dental care. Further, while at least 37 million Americans lack medical insurance, the National Dental Research Advisory Council reports that 150 million Americans lack dental insurance, and millions more are underinsured for health care, including oral health care.

Preventable oral diseases currently afflict the majority of children and adults in our country. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two-thirds experience gingivitis. Furthermore, nearly half of all employed adults have gingivitis and eighty percent have experienced periodontitis, according to the U.S. Preventive Services Task Force. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. Indeed, as many as four to fifteen percent of American adults, and more than forty percent of the elderly, have lost all their teeth. These individuals frequently experience nutritional deficiencies as a result of being unable to chew food. *Each of these oral health disorders—dental caries gingivitis and periodontitis—can be prevented through regular preventive care.*

Universal access to oral health services should be provided to all Americans as one way to support total health. Ideally, everyone should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Children, in particular, should be assured regular preventive services. The American Academy of Pediatrics supports a *fully funded* preventive care benefit package—which includes preventive dental care—as a component of its recommended basic benefit package for children. The Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program also recognizes the value of preventive oral health care for children, mandating coverage of these services for all Medicaid-eligible individuals from birth to age 21. Because of financial and other restrictions imposed by states, however, the September 1989 "Public Health Service Workshop on Oral Health of Mothers and Children" revealed that the Medicaid program continues to serve only a fraction of the children it was intended to serve.

Preventive oral health care has already proven beneficial. The National Institute of Dental Research (NIDR) reports that one-half of American children ages five to seventeen are now cavity free. Although the prevalence of dental caries among school-aged children has declined in recent years, 84 percent of 17-year-olds were found in a recent NIDR survey to have cavities. Further, the Centers for Disease Control reports that the oral health of African Americans and Hispanics is far worse than that of whites. For example, one of the most severe forms of gum disease—localized juvenile periodontitis—disproportionately affects teenage black males and can result in loss of all teeth before adulthood.

Americans with access to preventive dental services highly value this care, as illustrated by federal government workers. Last year, the *Washington Post* reported that 1.5 million of the four million current and retired federal workers who participate in the Federal Employees Health Benefits (FEHB) program choose the Blue Cross-Blue Shield policy, in part because of its preventive dental package, which includes dental exams, X-rays, prophyiaxis (cleaning) and fluoride treatments. In addition, Hewitt Associates (Hewitt), an international consulting firm specializing in employee benefit plans, reports that 92 percent of the health plans in its data base include dental coverage.[1] Hewitt also reports that employees ranked dental coverage second in importance only to medical coverage and before all other benefits, including paid time off, pension options, sick leave and life insurance.

COST SAVINGS ASSOCIATED WITH PREVENTIVE ORAL HEALTH CARE

Investing in America's oral health care will translate directly into fiscal savings. It is a known fact that preventive care can reduce the need for expensive critical care. In fact, NIDR reported in July 1992 that Americans saved nearly $100 billion

[1] Hewitt Associates March 30, 1993 testimony before the House Ways and Means Subcommittee on Health, "HealthCare Reform: Consideration of Benefits for Inclusion in a Standard Benefits Package," stated that it maintains a data base covering the salaried employees of over 1,000 major employers and the hourly and union employees of more than 200 major companies. These employers provide benefits to more than 20 million employees and 35 million of their spouses and dependents.

in dental bills during the 1980s because of improvements in oral health. Again, each $1 spent on preventive oral health care yields $8–$50 in savings.

Remarkably, while economic factors, such as population growth, increases in numbers of dentists, and increases in numbers of Americans with dental insurance, might have significantly increased the growth in dental expenditures over the past decade, National Income and Product Accounts data from the U.S. Commerce Department indicate that average annual growth in total real dental expenditures, adjusted for inflation, was only one percent annually from 1979 to 1989. This was substantially less than growth in medical expenditures. This slower growth in dental expenditures is estimated to have resulted in savings to the American public of more than $39 billion in 1990 dollars from 1979 through 1989. Increased emphasis on prevention, widespread use of fluorides, and a better-informed public contributed to those cost savings.

Even with these savings, however, there is room for significant improvement. In fact, the American Fund for Dental Health reports that 20 million work days are lost annually due to oral health problems. Increased access to preventive oral health services undoubtedly would reduce this staggering number and exponentially increase cost savings.

A working draft report prepared by the Public Health Service's Oral Health Coordinating Committee entitled "An Essential Oral Health Benefits Package" estimates an annual per capita cost of $74 to provide all American children with comprehensive oral health services[2] and all American adults with only acute emergency and preventive services.[3] Thus, the estimated cost of providing these services would be $19.2 billion for the entire population or $11.8 billion for the 160 million Americans who presently lack dental insurance. The report further estimates that extending comprehensive coverage to all Americans would entail a per capita cost of $134 or $34.9 billion for the entire population or $21.5 billion for the dentally-uninsured. [See attached table.]

ROLE OF DENTAL HYGIENISTS IN PROVIDING AMERICA'S ORAL HEALTH CARE

As the primary providers of preventive oral health services, dental hygienists stand ready to aid the nation in improving its delivery of oral health care and subsequently contributing to total health by providing valuable services such as routine prophylaxis; periodontal assessment, treatment and maintenance; application of fluorides and sealants; x-rays; and education in self care. By helping patients modify personal health behaviors to promote self care, dental hygienists assist individuals in playing a vital and cost-effective role in their own oral health.

As Congress reforms the health care delivery system, lawmakers thus should not view dentists as the gatekeepers of oral health services, akin to the primary care physician whose status may be elevated to that of gatekeeper of the provision of medical services in the future. The role of a dentist in the delivery of oral health care is not akin to that of a primary care physician. *The preventive oral health services which ADHA is advocating be included in a standard benefits package should be available to all Americans when provided by any state licensed provider. Both dental hygienists and dentists are licensed in all 50 states and therefore have demonstrated their competence to the satisfaction of state licensure boards whose mission it is to ensure the health, safety and welfare of the public. Further, dental hygienists receive three times the amount of education in preventive oral health services as do dentists.*

Federal legislation should ensure direct access to dental hygienists by providing for direct reimbursement in order to maximize Americans' access to preventive oral health care services. We must break down arbitrary practice setting barriers to access which have long tied oral health care delivery to the fee-for-service private dental office, where only 50 percent of the population is served. Several states, including Colorado and Washington, have endorsed direct access to dental hygienists through legislation which permits dental hygienists to practice independently. These

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[2] Services recommended include professional oral health assessment, consisting of thorough examination of the hard and soft tissues of the oral cavity and related structures provided on an annual basis, for those age two and older; dental sealants for permanent molar teeth in children; professionally-applied topical fluoride provided up to twice a year for children and adults who are assessed to be at risk for dental caries; oral prophylaxis (cleaning) for the removal of hard and soft deposits and extrinsic strain; and fluoride supplements made available to children until age 13 whose water supply contains sub-optimal levels of fluoride, acute emergency dental services, dental restorative services, and periodontal maintenance services.

[3] Adult preventive services would include oral health assessment, oral prophylaxis, periodontal maintenance services, professionally-applied topical fluoride for adults at risk for dental caries, and acute emergency dental services.

states expressly have recognized that full utilization of the services of dental hygienists can address the need to augment the delivery of oral health care. Federal law in no way should impede the progress that states are making in recognizing that dental hygienists appropriately may provide preventive oral health services outside of the purview of a dental office, thus breaking down the barriers which have impeded access to oral health services for too long.

A 1987 Federal Trade Commission study entitled *Restrictions on Dental Auxiliaries, An Economic Policy Analysis* recommends the elimination of licensing laws which limit the number of dental hygienists in a dentist's practice, finding that increased use of dental hygiene services will decrease costs to the consumer and improve access, without compromising quality. It is critical for federal legislation to buttress, and not impede, state law efforts to ensure increased access to dental hygiene services for children, the elderly, minorities, the poor, and the traditionally underserved. Indeed, recently proposed Medicaid EPSDT program rules for dental screening services would provide for referral to a dentist or a professional dental hygienist under the supervision of a dentist as an option to satisfy the requirement for initial referral for dental services. The stated rationale is to "increase the availability of dental services in areas where dentists are scarce or not easy to reach." Any federal legislation that provides for preventive oral health care services must protect patients' direct access to dental hygienists by providing for direct reimbursement.

CONCLUSION

In conclusion, preventable oral diseases still afflict the majority of children and adults in our nation, compromising their health and unnecessarily adding to health care costs. Ideally, all Americans should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, Americans need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays. Any federal legislation that provides for preventive oral health benefits also must ensure Americans' access to dental hygienists, the primary providers of preventive oral health care services.

ADHA stands ready to work with the nation's policymakers to ensure every American basic oral health and the savings of billions of health care dollars.

TABLE IV. Oral Health Benefits Package
Primary Preventive, Acute Emergency & Early Intervention Services
Targeted for Children, Adolescents, Adults, and Seniors

Basic Oral Health Services *Primary Prevention & Acute Emergency Services*	Target Population	Provider-Based Services (Guidelines / Modifiers / Estimated Costs)				
		Frequency of Service (N/Year)	Utilization Rate[a]	Specific Service Modifier	Estimated Unit Cost ($/unit)[b]	Estimated Annual Per Capita Cost
Oral Health Assessment	Children / Adolescents & Adults / Seniors					
• Initial Oral examination		1	70 %	–	$22	$15
• Periodic Oral Examination		1	70 %	–	$17	$12
• Dental X-rays (2 bitewings)		1	70 %	–	$16	$11
Dental Sealants	Children & Adolescents[c] (8 and 14 years)	1	50 %[d]	4 molars[e]	$19	$38
Professionally-Applied Topical Fluorides	Children & Adolescents (Non-Fluoridated Areas)	2	85 %[f]	45 %[g]	$16	$12
	Children & Adolescents (High Risk – Fluoridated Areas)	2	20 %[h]	55 %[i]	$16	$ 4
	Adults (High Risk of Caries)	2	70 %	10 %[j]	$16	$ 2
	Seniors (High Risk of Caries)	2	70 %	10 %[j]	$16	$ 2
Oral Prophylaxis (Dental Cleaning)	Children & Adolescents	1	70 %	60 %[k]	$28	$12
	Adults & Seniors	1	70 %	40 %[l]	$39	$ 11
Fluoride Supplements (Daily Supplements)	Children (13 years and under)[m]	1 (daily)	85 %[f]	45 %[g]	$16	$ 6
Acute Emergency Dental Services	Children / Adolescents & Adults & Seniors					
• Emergency Examination		1	15 %[n]	–	$23	$3
• Sedative Filling		1	2 %	–	$31	$1
• Emergency Tx of Pain		1	2 %	–	$34	$1
• Extraction (single tooth)		1	10 %	–	$47	$5
• Extraction (surgical)		1	1 %	–	$86	$1
• Traumatic wound Tx		1	1 %	–	$55	$1

Basic Oral Health Services *Early Intervention Services*	Target Population	Provider-Based Services (Guidelines / Modifiers / Estimated Costs)				
		Frequency of Service (N/Year)	Utilization Rate[a]	Specific Service Modifier	Estimated Unit Cost ($/unit)[b]	Estimated Annual Per Capita Cost
Dental Restorative Services (Dental fillings)	Children (Primary Teeth) (3 to 10 years)[c]	1	70 %	1.1 surfaces[p]	$38	$30
	Children & Adolescents (Permanent Teeth) (6 to 18 years)[q]	1	70 %	0.4 surface[r]	$44	$12
	Adults (Coronal Caries)	1	70 %	1.3 surfaces[s]	$44	$40
	Adults (Root Caries)	1	70 %	0.4 surface[t]	$44	$12
	Seniors (Coronal Caries)	1	70 %	1.54 surfaces[u]	$44	$46
	Seniors (Root Caries)	1	70 %	1.46 surfaces[v]	$44	$46
Periodontal Maintenance Services (Dental scaling and root planning)	Children & Adolescents	1	70 %	10 %[w]	$60	$4
	Adults	1	70 %	54 %[x]	$60	$23
	Seniors	1	70 %	66 %[y]	$60	$28

FOOTNOTES: **Assumptions used in the development of the Oral Health Benefits Package**

a Estimated utilization rate--The proposed oral health service package projects an overall utilization rate of 70 percent for the target population, unless disease conditions or other modifying factors warrant adjustment of this rate.[30] National dental care utilization data (NHIS, 1989) reports an overall annual utilization rate of 57 percent.[2] *Healthy People 2000* has set a goal of 70 percent utilization of the oral health care system for adults aged 35 years and older.[33] Recommend that future cost estimates be based on a utilization rate of 70 percent for all age categories.

b Unit cost of dental services--Cost estimates for individual clinical-based services are based on 1985 median fees from a national survey of dentists conducted by the American Dental Association[3] and adjusted to 1992 dollars.

c Eligible population--The services package targets the population of two age groups (8 and 14 year old children) for placement of dental sealants on susceptible permanent molar teeth, in any one year.[28] Recommend the application of sealants to a total of eight (8) permanent molar teeth per individual during the period of 7 to 15 years of age.[34]

d Utilization modifier--A modified utilization rate of 50 percent for sealant application is recommended based upon the target goal of 50 percent established in *Healthy People 2000*.[33] In 1989, only 17 percent of eight year old children, and 13 percent of children aged 14 years, were reported to have sealants.[2]

e Service modifier--The preventive services package recommends a single application of dental sealants to four (4) permanent molar teeth per individual, in any one year, during the period of 7 to 15 years of age.

f Utilization modifier--The benefit package employs an 85 percent utilization rate, which corresponds to the *Healthy People 2000* target goal for individuals not receiving optimally fluoridated public water.[33]

g Service modifier—The Centers for Disease Control and Prevention (CDC) estimates that approximately 112 million people (or approximately 45 percent) in the U.S. (1989) did not have access to the benefits of optimally fluoridated water, either through adjusted or naturally occurring means.[6] Assuming the U.S. population served by community and non-community water supplies is distributed evenly by age category, this service package assumes that 45 percent of the child population consumes drinking water with less than optimal levels of fluoride. Thus, this figure represents the proportion of the U.S. population not receiving water with a dentally significant concentration of fluoride and would benefit most from the application of professionally-applied topical and systemic fluoride supplements. Children and adolescents consuming dentally significant concentrations of fluoride in their drinking water should not be prescribed dietary fluoride supplements.

h Utilization modifier—A modified utilization rate of 20 percent is used in the model to represent the proportion of the U.S. child population at high risk of experiencing dental caries, and thus would benefit from additional topical fluoride treatment—even those residing in fluoridated areas. This estimate is based on the 1986-87 National survey of oral health in school children that reported 60 percent of the decayed teeth in children were found in 20 percent of the individuals surveyed.[15]

i Service modifier—The CDC estimates that over 128 million people (1989) in the U.S. in more than 8,081 communities are receiving the benefits of optimally adjusted fluoridated water, and an additional 9 million people in 1,869 communities are using water with naturally occurring fluoride at levels of 0.7 mg/liter or higher.[6] Assuming the child population served by community and non-community water supplies is distributed evenly by age category, the service package used the estimate of 55 percent as the proportion of the U.S. child population with access to drinking water with a dentally significant concentration of fluoride. This population would not benefit significantly from professionally-applied topical fluoride, unless there is evidence the individual is at increased risk of dental caries (see footnote h).

j Service modifier—The National Institute of Dental Research (NIDR) conducted the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors and reported that approximately 7 percent of employed adults (dentate) aged 18-64+ years were caries free, and about 3 percent of dentate seniors aged 65+ (dentate) were caries free.[18] Although only a small proportion of adults/seniors were found to be caries free, an estimate of 10 percent was project as the proportion of adults/seniors at increased risk of active dental caries and would benefit from fluoride supplements. The service modifier is based upon the survey findings that the decayed component (D) of caries scores (unrestored tooth surfaces) comprised approximately 8 percent in employed adults and 9 percent in seniors of the decayed and filled tooth scores (DFT).[18]

k Service modifier—The proportion of children and adolescents requiring "routine oral prophylaxis" is estimated to be 60 percent. This estimate is based on the 1986-87 NIDR National Survey of Oral Health in School Children which reported 59 percent of children aged 14-17 years demonstrated gingival bleeding upon probing.[19] Gingival bleeding serves as an indicator for mild or moderate gingival inflammation and an indirect measure of treatment need required.

l Service modifier—Approximately 89 percent of the adult population aged 18 and older is classified as dentate.[18] The proportion of dentate adults aged 19 to 64 years and dentate seniors aged 65+ years requiring "routine oral prophylaxis" is estimated at 40 percent. Projection based of data from the 1985-86 NIDR National Survey of Oral Health in U.S. Employed Adults and Seniors — 43.6 percent of employed adults (dentate) aged 18-64+ years were reported with gingiva bleeding in at least one site; and 46.9 percent of seniors (dentate) were reported with bleeding gingiva.

m Eligible population—The target population includes infants and children, 13 years of age and younger. Daily use of dietary fluoride supplements is recommended for infants (pediatric drops) and children (fluoride tablets) up through the age of 13, who reside in areas not served by fluoridated public or private water supplies.[14]

o Estimated utilization rate—The estimated need for emergency dental services is 15 percent. Based on data from the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors — 18.6 percent of employed adults, and 16.2 percent of seniors self-reported the need for "immediate" dental treatment.[18] From the same national survey, 14 percent of adults and seniors reportedly sought dental care for either a toothache or to have a tooth extracted.[18]

o Eligible population—The benefit package targets the population of children, aged 3 to 10 years, at risk of experiencing dental caries in their primary dentition.

p Service modifier—Based upon the findings of the 1986-87 National Survey of Dental Caries in U.S. School Children, the mean number of decayed (unrestored) primary tooth surfaces requiring restoration was 1.1 tooth surfaces. The mean decayed and filled tooth surfaces score (dfs) for children aged 5-9 years was reported as 3.9 surfaces (the decayed component was 28 percent).[19]

q Eligible population—The benefit package targets the population of children and adolescents, aged 6 to 18 years, at risk of experiencing dental caries in their permanent dentition.

r Service modifier—Based upon the findings of the 1986-87 National Survey of Dental Caries in U.S. School Children, the mean number of decayed (unrestored) permanent tooth surfaces requiring restoration was 0.4 of a surface. The mean decayed, missing, and filled tooth surface score (DMFS) for children and aged 5-17 years was reported as 3.07 surfaces (the decayed component comprised 13.4 percent).[19]

s Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) coronal surfaces for employed adults aged 18 to 64+ was 1.3 surfaces. The mean decayed and filled coronal surfaces score (DFS) was reported as 23.2 surfaces (the decayed component comprised 5.6 percent).[18]

t Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) root tooth surfaces for employed adults aged 18 to 64+ was 0.4 of a surface. The mean decayed and filled root surfaces was reported as 0.76 of a surface (the decayed component comprised 53.5 percent of the DFS score).[18]

u Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) coronal surfaces for seniors aged 65+ was 1.54 surfaces. The mean decayed and filled coronal surfaces score was reported as 20.4 surfaces (the decayed component comprised 7.6 percent of the DFS score).[18]

v Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) tooth surfaces for seniors aged 65+ was 1.46 surfaces. The mean decayed and filled root surfaces score was reported as 3.17 surfaces (the decayed component comprised 46.1 percent of the DFS score).[18]

w Service modifier—Based upon the findings of the 1986-87 National Survey of Dental Caries in U.S. School Children, 10 percent of children and adolescents were estimated to require dental scaling services beyond the "routine oral prophylaxis."

x Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, 53.7 percent of employed adults aged 18 to 64+ were reported with findings of subgingival calculus.[18]

y Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, 65.6 percent of seniors aged 65+ years were reported with findings of subgingival calculus.[18]

TABLE V. Estimated Cost of Oral Health Benefits Package
(Implementation of the Various Clusters of Oral Health Services)

Target Population	Oral Health Benefits Package *(Estimate Cost of Implementation & per capita cost)*[b]		
	Cluster "A" Services *($134 per capita)*	Cluster "B" Services *($74 per capita)*	Cluster "C" Services *($35 per capita)*
Total U.S. Population[a] (260.1 million)	$34.9 billion	$19.2 billion	$ 9.1 billion
Dental Uninsured Population[a] (160 million)	$21.5 billion	$11.8 billion	$ 5.6 billion
Population in Poverty (100 % of Federal Poverty Level)[c] (Estimated 74 million)	$ 9.9 billion	$ 5.5 billion	$ 2.6 billion
Population in Poverty (150 % of Federal Poverty Level)[c] (Estimated 54 million)	$ 7.2 billion	$ 4.0 billion	$ 1.9 billion
Population in Poverty (100 % of Federal Poverty Level)[c] (Estimated 34.5 million)	$ 4.6 billion	$ 2.5 billion	$ 1.2 billion

Footnotes:

[a] Based on 1995 U.S. population estimates.

[b] Median dental fees obtained from 1985 American Dental Association national survey of general dental practitioners' adjusted for inflation to 1992 dollars.

[c] Based on 1992 U.S. population estimates.

(2) **Oral Health Benefits Package – Cluster "B" Services:**
(Primary Preventive, Acute Emergency, and Early Intervention Services for Children and Adolescents & Primary Preventive and Acute Emergency Services for Adults)

Cluster "B" services *(TABLE VII)* represents a lower cost alternative. Services for children are identical to those in cluster "A", but only acute emergency and preventive services are extended to adults.

At an annual per capita cost of $74, the estimated annual cost of implementing this cluster of services for the entire U.S. population is $19.2 billion (50 percent of the 1992 total expenditure for dental services in the U.S.), and $11.8 billion for the dental uninsured population *(TABLE V)*.

Although this package would have a positive impact on oral health, attainment of the oral health objectives of ***Healthy People 2000*** for adults and seniors would be unlikely by the year 2000.

TABLE VII. **Oral Health Benefits Package – Cluster "B" Services**
Primary Preventive, Acute Emergency and Early Intervention Services Targeted for Children & Adolescents
Primary Preventive and Acute Emergency Services Targeted for Adults & Seniors

Basic Oral Health Services *Primary Prevention Services* *Acute Emergency Services* *Early Intervention Services*	*Healthy People 2000* *Relevant* *Oral Health Objectives*	Target Population *Children & Adolescents (2-18 yrs.)* *Adults (19-64 yrs.)* *Seniors ((65+ yrs.)*
Oral Health Assessment • Oral Examination *(Initial exam)* • Oral Examination *(Periodic exam)* • Dental Radiographs *(2 bitewings)*	Objective 13.07 Objective 13.11 Objective 13.12 Objective 13.13 Objective 13.14 Objective 13.16	Children & Adolescents
		Adults & Seniors
Dental Sealants	Objective 13.01 Objective 13.08	Children & Adolescents (8 and 14 yrs.)
Professionally-Applied Topical Fluorides	Objective 13.01 Objective 13.10	Children & Adolescents (Non-Fluoridated Areas)
		Children & Adolescents (High Risk – Fluoridated Areas)
		Adults
		Seniors
Oral Prophylaxis *(Dental Cleaning)*	Objective 13.05	Children & Adolescents
		Adults & Seniors
Fluoride Supplements *(Daily Supplements)*	Objective 13.01 Objective 13.10	Children (13 yrs. and under)
Acute Emergency Dental Services *(Relief of acute pain and infection)*	Objective 13.02 Objective 13.13	Children & Adolescents
		Adults & Seniors
Dental Restorative Services *(Dental fillings)*	Objective 13.02	Children (3 to 10 yrs.) (Primary Teeth)
		Children & Adolescents (6 to 10 yrs.) (Permanent Teeth)
Periodontal Maintenance Services *(Dental scaling and root planing)*	Objective 13.12	Children & Adolescents

STATEMENT OF THE AMERICAN LUNG ASSOCIATION

These comments are submitted on behalf of the American Lung Association and its Medical Section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society—a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research—the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

Every year, nearly 315,000 Americans die of lung disease. Lung disease is now America's number three killer, responsible for one in seven deaths. That rank may change. The lung disease death rate is climbing, while the rates for America's first- and second-ranked causes of death, heart disease and cancer (except for lung cancer), are dropping. From 1979 to 1991 the lung-disease death rate rose by 19.6 percent, while the death rate from heart disease fell a dramatic 25.7 percent.

A little over three years ago, and in part because of these grim statistics, the ALA/ATS began deliberating the issue of health care reform, looking at the issue from the unique perspective of the needs of people with chronic lung disease. In 1992, we formalized our thoughts in a policy statement that was approved by the respective Boards of Directors of the two organizations. A copy of our policy statement is included with this testimony. First and foremost, we support universal coverage for all U.S. citizens and legal residents. The coverage must be portable, prohibit pre-existing condition exemptions, and be affordable as well. We support a uniform, comprehensive benefits package, and our statement provides details of what we believe the standard benefits package should look like,giving examples of pulmonary-specific benefits. A chart detailing that discussion is located on page 3 of our attached policy statement. Also, the ALA/ATS specifically endorses continuation of an employer-based system that mandates employer participation with mechanisms to facilitate that participation.

The Health Security Act, S. 1757, is the only health care reform proposal that meets the overall policy recommendations of the ALA/ATS.

COMPREHENSIVE BENEFITS PACKAGE

Preventive Benefits

ALA/ATS Recommends that:

- **influenza immunization be provided for all at-risk individuals, regardless of age,**
- **a mechanism be in place to allow for frequent changes in immunization indications,**
- **health education benefits be made mandatory, and**
- **asthma education and asthma self-management be covered under health education.**

The ALA/ATS supports a uniform package of basic benefits that includes the appropriate levels of preventive, acute, chronic, and rehabilitative care. Although we do not specifically include long-term care benefits in our position paper, we would also support the inclusion of long-term care benefits in a basic benefits package. We are pleased to see that the Health Security Act has included the influenza vaccine and pneumonia vaccine in the preventive benefits section of his reform package. However, we are concerned that the influenza vaccine would only be specified for those individuals age 65 and over. In years such as this current year, when the strain of influenza is expected to be unusually severe, we recommend that ALL individuals at-risk get their influenza vaccine, not just those over 65. Others at-risk include:

- health care workers of all ages;
- residents of nursing homes and other chronic-care facilities housing persons of any age with medical conditions;
- adults and children with chronic cardiovascular or respiratory disorders, including children with asthma;
- adults and children who have required regular medical follow up or hospitalization during the preceding year because of diabetes mellitus or other chronic metabolic disorders kidney dysfunction, blood disorders, or the immunosuppression that can be caused by AIDS or various cancer treatments; and

- children and teenagers—from 6 months to 18 years—who are receiving long-term aspirin therapy, and therefore may be at risk of developing Reye syndrome after influenza.

We recommend that influenza immunization be available to all at-risk populations. The pneumonia immunization is probably appropriate for those age 65 and over. However, as indications for immunization can change frequently, it is important to maintain flexibility. There must be a ready mechanism in the benefits plan to deal efficiently and effectively with these types of necessary changes.

Health Education

The ALA/ATS strongly supports health education as an integral part of preventive health care. These programs will encourage individuals to maintain healthy lifestyles and take responsibility for positive health behavior. However, we are concerned that these benefits are left to the discretion of the various health plans. The ALA/ATS believes these benefits should be mandatory and include provisions for smoking cessation and asthma education and self-management training, among others.

Smoking cessation is imperative in any benefits package. Tobacco is the only product that, when used as intended, causes disease and death. 419,000 deaths a year are attributed to smoking. The morbidity and mortality associated with second-hand tobacco smoke raise the stakes even higher. Maternal smoking during pregnancy accounts for an estimated 20 to 30 percent of low-birth weight babies, up to 14 percent of preterm deliveries, and some 10 percent of all infant deaths. Smoking costs the United States at least $65 billion each year in health care costs and lost productivity. As a further preventive health measure, we strongly support increasing the excise tax on tobacco products by $2 per pack.

The ALA/ATS recommends that other health education benefits such as asthma education and asthma self-management be included in a mandatory health education benefits package. Asthma is, in fact, the most frequent reason for hospitalization due to chronic disease in children and teens under age 15. Asthma is also the number one cause of school absences attributed to chronic health problems. If students are taught how to manage their asthma—what triggers an attack, how to avoid those triggers, what to do should an attack occur, and how to effectively use their medications—trips to the emergency room, hospitalizations, and lost school days can be reduced significantly.

The ALA/ATS also believes that comprehensive school health education is necessary for instilling positive health habits in our children. Such a program should include information on health-risk behaviors such as tobacco use and drug abuse, environmental health concerns, personal health, nutrition, and the prevention and control of diseases.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations, and others to join the voluntary health community in providing comprehensive health education.

CHRONIC CARE AND REHABILITATION BENEFITS

ALA/ATS Recommends that:

- **a wide range of outpatient benefits be provided,**
- **oxygen benefits be retained under Durable Medical Equipment,**
- **a national coverage policy be established for home oxygen use, and**
- **criteria be ensured for rehabilitation services to allow for maintenance or nondeterioration in condition.**

Lung disease doesn't always kill. It may simply make each breath barely possible—a constant, moment-to-moment struggle to stay alive. Nearly 26 million Americans are now living—often painfully—with chronic lung disease. At least 14.2 million suffer from chronic obstructive pulmonary disease (COPD), the fourth-ranking cause of death. COPD includes emphysema, which afflicts approximately 1.65 million Americans, and chronic bronchitis, which affects nearly eight times as many—12.5 million people.

Classic emphysema develops over many years of assault on lung tissues. Breathing falters and, ultimately, each breath becomes a chore. In the end, patients are dependent on oxygen, even at rest. The damage, and the disease, are irreversible. In most cases, therapy is limited to relief of symptoms and attempts to improve the patient's general quality of life.

Like emphysema, chronic bronchitis typically develops over many years. Many of those who suffer from it are subject to periodic attacks of obstructed breathing, when their lungs become inflamed and clogged.

Sarcoidosis can attack any organ of the body, but it most frequently affects the lungs. Pulmonary sarcoidosis causes stiffness in the lungs and a decrease in the amount of air the lungs can hold. Although the disease can be found throughout the world, it is particularly prevalent in middle-aged, African Americans. If a case of pulmonary sarcoidosis becomes serious, it can develop into pulmonary fibrosis—the abnormal formation of fiber-like scar tissue in the lung. This distorts the structure of the lungs and can interfere with breathing. This can result in yet another chronic lung disease, bronchiectasis, in which pockets form in the air tubes of the lung and become sites for infection. Corticosteroid drugs are the primary treatment for sarcoidosis.

Astha is another chronic lung disease. An attack finds the victim gasping for breath as the airways become constricted. Between 1979 and 1991, the hospitalization rate for asthma rose 24.2 percent. The reasons for this increase are currently unknown but are the subject of extensive scientific investigation. For those who suffer from asthma, treatment typically means a variety of medications, some used regularly to stave off trouble, other to counter acute attacks. They include bronchodilators, corticosteroids and other reducers of inflammation, and a variety of agents designed to minimize allergic reactions. Complying with often complex treatment regimens can prove particularly difficult for children.

Although lung transplantation may be an option for some patients with endstage lung disease, it certainly is not appropriate for all patients with chronic respiratory-related diseases. Most medical care for diseases such as sarcoidosis, and severe COPD, involve proven, highly effective treatments such as periodic physician visits, drug therapies, supplemental oxygen, and, for some, pulmonary rehabilitation. For many of these patients, support groups, health education classes and in some cases, psychological counseling. may be necessary to help teach patients how to live with their disease, and cope with the changes in their lifestyles. Such chronic or "maintenance" benefits are the reality that help these patients live a relatively normal life in their own home.

We recognize that durable medical equipment is covered in the Health Security Act. We recommend that this include, as has been the case in the past, the administration of supplemental oxygen and supplies needed by many chronic lung disease patients. However, the ALA/ATS would like to see a national coverage policy with respect to home oxygen use. Even within the Medicare program, there is no national, uniform coverage policy. This gap creates unnecessary confusion for the patient and the providers over what treatment is covered for which diseases and symptoms.

The ALA and ATS would also caution that all forms of successful rehabilitative care do not necessarily affect the outcome of the patient's condition. For patients with chronic lung disease, the major benefits of pulmonary rehabilitation are improvements in quality of life. The objectives of pulmonary rehabilitation are to control and alleviate symptoms and complications and to achieve optimal ability to carry out activities of daily living. Pulmonary rehabilitation may consist of a variety of activities from exercise training to increase breathing capacity, to breathing retraining, energy conservation and nutrition counseling. For many patients, rehabilitation keeps them at an even level, but more importantly it prevents further deterioration in their condition. We hope that such assistive rehabilitations are not lost in the move to cure all patient ills.

ACCESS TO SPECIALTY CARE

ALA/ATS Recommends that:

- **all managed care systems guarantee patient access to appropriate and timely primary and specialty care.**

Although the American Lung Association and the American Thoracic Society support the need to train more primary care providers, we are concerned that lung disease patients have access to the appropriate specialty care their condition demands. Specialists serve a dual role in clinical practice as a primary care physician for a person with a chronic disease/condition and as a consultant for acute illness where the patient has been referred to the specialist. A gatekeeper system that too strictly requires permission/referral for every visit to a specialist would be a large detractor to access for people with chronic lung conditions. Appropriate management of moderate to severe asthma or sarcoidosis by a specialist, for example, is more likely to result in fewer hospitalizations than care of those same cases by a general internist

or family practitioner who does not have the extra, necessary training. In fact, pulmonary physicians are well trained to assume full care for the patient whose primary problem is lung-related.

The Health Security Act raises a concern among patient groups that access to providers who are specialists for individuals with chronic diseases (e.g. specialist acting in the primary care provider role) may be denied, or severely restricted in the interest of cost savings. Financial disincentives for specialty referral must be eliminated. Referrals must be based on the best interest of the patient, not the financial interests of the health plan.

BENEFITS DISCLOSURE

ALA/ATS Recommends that:

- **health plans provide full disclosure of benefits.**

Once the benefits package is established, health plans must be required to disclose the full spectrum of benefits, including any additional benefits that may be provided. It is important for individuals, such as people with astma, to know that they will have access to the range of benefits they need to maintain a healthy lifestyle, including the correct pharmaceuticals, nebulizers, peak flow meters, spacers, tubing, asthma education, and so forth. These benefits must not only be fully disclosed, but also defined in easy-to-understand terms. Patients must be able to comprehend exactly what they are receiving, or more importantly, be assured that they will receive the benefits they need.

EMPLOYER MANDATE

ALA/ATS Recommends that:

- **an employer mandate be included with subsidies to assist small businesses.**

The ALA/ATS believes any new health care system should be built upon our current public/private system. We support an employer-mandated system in which mechanisms and incentives are established to help employers finance health care benefits for their employees and the employees' dependents. We believe this would be the least disruptive way to achieve universal coverage, the primary tenet of our position. Our statement proposes a list of benefits the we believe must, at a minimum, be included in the employed financed package. Employers should certainly be free to offer benefits above and beyond those mandated. Individuals also should be allowed to purchase supplemental coverage on their own if they so choose.

In the past forty years, Americans have come to rely on their employer as the provider of health insurance. While the Health Security Act does not mandate that the employer choose the one or two plans to be offered to their employees, it does require the employer to serve as the chief or primary contact for the employee to deal with the overwhelming and daunting health insurance system. Workers already are comfortable with that arrangement. The role of the employer certainly changes under the Health Security Act from that of benefits administrator, to more of a facilitator of information. It appears this would be a less time-consuming and less costly role for the employer, while retaining the current relationship with the employee. Individuals who are uncomfortable obtaining health insurance through their employer have the option to work directly with the regional health alliance. An employer mandate would level the playing field among different employers, most of whom provide such coverage today. It would eliminate unequitable cost shifts that employers bear today for the uninsured workers of other employers, as well as the cost-shift that all payers of health services encounter due to other uncompensated care and inadequate Medicare and Medicaid payments. According to a 1991 Lewin/ICF study on cost-shifting, if all forms of cost-shifting were eliminated, employer health costs could be reduced by approximately 10 percent. The ALA/ATS does not believe that the health care system should be financed totally by either the government or the private sector. But rather, the current sharing of responsibility is the appropriate way to proceed. We realize that some employers and individuals will need financial help to meet their obligation. Therefore, the proposal for employers to finance partial coverage, with assistance from the government, is ideal. This arrangement does not preclude individual responsibility for paying for a part of his or her health care costs, again with governmental assistance if necessary.

INSURANCE REFORMS

ALA/ATS Recommends that:

- **all pre-existing condition limitations be prohibited,**
- **coverage must be guaranteed renewable and guaranteed issue,**
- **premiums must be community rated, and**
- **the medical portion of worker's compensation be consolidated into the new plan**

The ALA/ATS supports the need for changes in our current health insurance industry to ensure universal health care coverage. Most of these changes are included in the Health Security Act and other proposals. Primarily, all pre-existing condition clauses or mandated waiting periods must be eliminated. For people with chronic conditions, even a six-month delay in coverage could be catastrophic. If the particular treatment is expensive, the person may become bankrupt in the intervening time, or forego the expensive treatment, thereby increasing the severity of their condition—and in all likelihood the ultimate cost of treating their illness—for when they do become eligible for coverage.

The ALA/ATS believes that coverage must be guarateed renewable and that coverage should not be cancelled for any reason, including nonpayment of premiums. Although every effort should be made to ensure that individuals who can afford to pay for their treatment do so, inability to pay for care must not be the deciding factor in care delivery.

Community rating must also be ensured. People who are sick must have access to the health care system. Charging them more to receive the benefits they need—which, in fact, the current premium system does—is inherently wrong. This approach must be changed to a system that treats everyone equally. Many diseases, conditions, or injuries are unavoidable and people should not be penalized for becoming ill or disabled.

The ALA/ATS also supports the consolidation of the medical portion of the worker's compensation plan into the new system. This program has created jurisdictional problems from both an insurance perspective and a health care management perspective; we welcome the president's proposal in this area.

CONSOLIDATION OF FEDERAL HEALTH PROGRAMS

ALA/ATS Recommends that:

- **all federal health programs be consolidated into the new plan.**

The ALA/ATS supports the proposal in the Health Security Act to consolidate the Federal Employees Health Benefits program and the Medicaid program into the new system. We also support the consolidation of all other federally funded health programs into a single entity. We would include in this consolidation programs currently funded through the Veterans Administration, the Department of Defense, the Indian Health Service, the migrant health centers, and so forth. We believe this would eliminate costly duplication of physical structures, equipment purchases, and personnel. This consolidation would also stream-line government functions. Instead of having multiple rules, regulations, and procedures—not to mention forms—one single procedure could be used by all federal health systems.

PUBLIC HEALTH INITIATIVES

Medical Research

ALA/ATS Recommends that:

- **additional funding for medical research be ensured through a dedicated revenue source.**

The ALA/ATS is pleased that the Health Security Act includes provisions for medical research. A strong basic biomedical research program is the basis for a strong health care delivery system.

We also believe that health care dollars can be saved in the long-term through improved diagnostic tools and treatments developed as a result of medical research breakthroughs.

The Act places a new emphasis on medical research in two areas, preventive services and health services research. Although the bill as introduced lists only broad categories for the new research emphasis, an earlier draft included provisions of specific interest to the ALA/ATS such as prevention of dependence on tobacco, research on new vaccines to prevent tuberculosis and to develop better tuberculosis diagnostic tools, and a new emphasis on identifying environmental health hazards. The ALA/ATS is concerned, however, that funding for these new research initiatives is subject to the regular Congressional appropriations procedures, and therefore, is not guaranteed. We support a supplemental, dedicated revenue source, such as the

one being advocated by Senators Harkin and Hatfield, that guarantees a new funding pool for basic biomedical research. We would also express caution to ensure that this new emphasis on biomedical research does not detract from or reduce funding for other ongoing, and equally important, biomedical and health services research.

Public Health Programs

ALA/ATS Recommends that:

- **additional funding for public health initiatives be guaranteed.**

The Health Security Act is the only proposal pending before Congress that addresses the needs of the public health system. We applaud these initiatives. The plan seeks to redirect the current focus of the nation's public health system away from the direct provision of services, and back toward the more historical and traditional public health programs that monitor and protect communities from communicable diseases and exposure to environmental and occupational hazards, and identify and control infectious diseases.

We also support the new National Initiatives on Health Promotion and Disease Prevention that are included in the bill. Of specific interest to the ALA/ATS are provisions that allow the Secretary of Health and Human Services to make grants to local government agencies, private nonprofit organizations, and coalitions of such agencies to develop and implement community-based health promotion and disease prevention activities. This is an extension of the current role/relationship that the ALA/ATS enjoys with state and local health departments in many areas. We look forward to continuing and strengthening this important relations.

However, we are concerned as funding for these programs is also subject to the regular appropriations process. In the early 1970s, Congress eliminated funding for public health programs in the area of tuberculosis prevention and control. As a result of this and other breakdowns within. the public health infrastructure, we are facing an extraordinary increase in the number of TB cases in the United States, over 20% in just seven years. Funding for these important programs must be ensured, through some type of direct funding mechanism, or exemption from the current cap on discretionary spending.

SUMMARY

In summary, the ALA/ATS supports a full continuum of benefits, appreciating the emphasis on prevention, ensuring coverage of benefits for people with chronic conditions to help them maintain a quality of life within the parameters we term "normal," and guaranteeing access to specialty care as is appropriate. Patients must also be made aware of what the full benefits package includes, in detail, and the information must be presented in a way that is comprehensible to the average person.

The ALA/ATS also supports a mandate on employers to help finance health care benefits for their employees and the employees' dependents The system must include mechanisms that allow and ensure compliance with this mandate. The benefits provided by the employer must be comprehensive and uniform for all individuals, with the option for either the employer or the employee to purchase supplemental benefits. The ALA/ATS also supports changes to the current system to eliminate cherry picking and other cost avoidance mechanisms used by the health insurance industry. The ALA/ATS supports the consolidation of all federal health programs into one single entity. Finally, the ALA/ATS supports a strong medical research component and a strengthening of the public health infrastructure, with a secure funding mechanism for each.

Position Statement of the ALA/ATS Health Care Policy Task Force

REFORM OF THE U.S. HEALTH CARE SYSTEM

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the Lung Association provides programs of education, community service, advocacy and research to fight lung disease and promote lung health.

Based on this mission, we believe our health care system must meet the multiple needs of people with lung disease. It is widely recognized that far too many people are without access to even the most basic of health care services in our current health care system. This structure, therefore, does not meet the needs of people with lung disease or other diseases existing in our society today.

A strong national medical research agenda as well as an effective medical education program are critical to our health care system. However, after considerable discussion, the Task Force agreed that this document was not the proper place to consider these significant yet slightly tangential issues.

The ALA/ATS believes that patients (consumers of health care) and deliverers of health care must have an effective voice in the health care reform debate. As advocates for persons with lung disease and representing people who deliver health care, we therefore call on Congress and the federal government to enact comprehensive health reform that takes into account the principles outlined in this document. We recognize the complexity involved in these proposed changes and the need for a structure to represent the diverse constituencies to implement the changes.

ALA/ATS POSITION STATEMENT ON HEALTH CARE POLICY

The ALA/ATS supports the development of a health care system that will meet the special needs of patients with lung disease based on the following criteria:

ELIGIBILITY

ALA/ATS POSITION: Health care is a right. Our health care system(s) must guarantee access to a basic level of services for all residents of the United States regardless of employment status, ability to pay, pre-existing condition or other factors such as, but not limited to, age, gender, sexual orientation, or racial or ethnic background.

We believe health care is a right to which individuals are entitled by virtue of their existence. We recognize and separate this right from those rights that are guaranteed through the Constitution of the United States and the legal system of the United States. Residents of this nation must not be excluded from the health care system for any reason.

Although we believe all U.S. residents must have access to the health care system, we recognize that parameters must be set with regard to the breadth of services provided. For that reason, we support a basic level of health care services to which all residents are entitled. Unfortunately, the United States simply does not have the resources to guarantee unlimited health care coverage to all individuals.

COVERAGE AND BENEFITS

ALA/ATS POSITION: Comprehensiveness -- The basic level of services must be the same for all individuals. These services include appropriate levels of preventive, acute, chronic, and rehabilitative care, and must be provided so as to preserve continuity of care. Access to these services must continue regardless of the cause of illness, or an individual's employment, physical, mental, geographic, or financial state.

ALA/ATS POSITION: Quality of Care -- The basic level of services should be effective, appropriate, and timely. Medical effectiveness is defined by research findings. Appropriateness is determined by the patient, the family, and the health care team. Timely means without delays that would otherwise adversely affect the outcomes of care.

ALA/ATS POSITION: Basic Level of Services -- These services should be broad-based and the same for all individuals. Services to be provided are listed on the following page.

BASIC HEALTH CARE SERVICES TO BE PROVIDED

	Basic Health Services	Pulmonary-Specific Examples
Preventive	Prenatal care Well baby/well child Family planning services Childhood immunizations Adult immunizations Education Periodic health examinations Effective therapies for at-risk populations	TB skin test Appropriate testing for congenital processes (cystic fibrosis, alpha-1 antitrypsin deficiency) TB prophylaxis Influenza, pneumococcal vaccine Smoking cessation programs Pentamidine aerosol (HIV) Screening for occupation- and environment-related pulmonary problems Routine and complaint-specific clinical evaluations
Outpatient	Diagnostic evaluation: history, physical examination, testing, procedures, chronic therapy Prescription drugs	Diagnostic evaluation: routine physical problem-directed history, physical examination Diagnostic testing: radiologic imaging, pulmonary functions Outpatient procedures: thoracentesis, fiberoptic bronchoscopy Ongoing treatment for chronic problems: chronic obstructive pulmonary disease – COPD (chronic bronchitis, emphysema), cystic fibrosis, sarcoidosis, asthma, occupational lung diseases
Inpatient	Extensive diagnostic evaluation Complex treatment of both acute and chronic conditions	Follow-up for positive findings on diagnostic evaluation Treatment for serious exacerbation of chronic problem(s): COPD Treatment for serious exacerbation of acute problems: pneumonia
Rehabilitation	Physical therapy Occupational therapy Supportive care: nursing facilities, home care, durable medical equipment, respite, hospice Mental health services: substance abuse	Physical therapy Occupational therapy Respiratory therapy Pulmonary rehabilitation Supportive care: home care, chronic ventilator care, oxygen

We believe all societal barriers must be eliminated, including jurisdictional questions over coverage, so all individuals have access to the same, uniform set of services and that these services are portable. The guaranteed services should span the continuum of coverage from preventive health services including prenatal and pregnancy care, immunizations, and health screenings to acute services including inpatient hospital care and outpatient services, and chronic and rehabilitative care. In all cases, the services provided must be medically effective as defined through research findings; appropriate as determined by the patient, family and health care team; and timely -- without delay due to financial or administrative barriers. We also realize that there are societal interests that may be affected in the provision of care.

STRUCTURE

ALA/ATS POSITION: We favor a health care system that is a pluralistic public/private payment and delivery system. Mechanisms must be established to facilitate the requirement of employers to finance the health care benefits of their employees and employees' dependents. Supplemental benefits can be provided in whole or in part by the employer, or purchased privately by the individual.

We recommend that all federally-sponsored health care programs be consolidated into a single public plan.

We believe the new health care system should build upon our current public/private system. We support an employer mandated system in which mechanisms and incentives would be established to help employers finance health care benefits for their employees and the employees' dependents. Under this proposal, the employer could, for example, provide health care benefits directly as a self-insured program or purchase a group plan as long as the benefits financed by the employer include **at a minimum** all the services listed in the Benefits section on page 3. Employers would certainly be free to offer benefits above and beyond those mandated. Individuals also would be allowed to purchase supplemental coverage on their own, if they so choose.

It may also be necessary to effect changes at the federal government level with respect to small market insurance laws (i.e., guaranteed issue, guaranteed renewability, community ratings) to facilitate employer compliance. In addition, procedures must be in place to ensure that health care services are provided in instances of jurisdictional coverage dispute (e.g., workers' compensation versus traditional insurance).

We strongly believe that all federally-sponsored health care programs should be consolidated into a single public plan that provides all the services listed in the Benefits section on page 3. This plan would include

the Medicare program, Medicaid, Veterans' Administration health programs, CHAMPUS, community and migrant health programs, and so on. It would eliminate the duplications of administration and delivery of services among these many programs. It also would allow for a uniform public program that would not vary by state (as is the problem with Medicaid), and allow access to services regardless of the nature of the illness (as with the VA programs).

SYSTEMIC AND PROVIDER CONCERNS

ALA/ATS POSITION: Administrative -- The administration of the health care system must facilitate patient access to care. The administrative process of the health care system must be standardized for all payers, thus maximizing resources for actual health care services.

ALA/ATS POSITION: Provider Reimbursement and Availability -- Providers must be fairly compensated to ensure access to health care. This compensation should reflect provider cost, work, and time. Incentives must be developed to encourage an appropriate distribution between primary care and specialty physicians and a more equitable distribution of health care providers to ensure access to care in rural, inner city, or otherwise underserved areas.

We believe the system must be "user friendly" and easily accessible to patients. We believe the administrative processes of the health care system must be simplified and standardized for all payers so that more of our health care dollars are spent in providing health care services, and less for paying salaries of people hired to fill out forms. Reforms in this area could include electronic filing of claims, a single uniform insurance form, or "smart cards" for individuals.

We also believe all providers of health care (physicians, nurses, nurse practitioners, clinical nurse specialists, physician assistants, allied health professionals, and hospitals) should be reimbursed at a fair rate so as to ensure full access for patients to all providers. We also believe incentives must be created within the medical education system to ensure the availability of a full range of providers in all geographic regions, especially in areas that are traditionally underserved. A strong primary care network must be developed to act as the entrance point for individuals into the health care system.

To achieve these goals, we make the following recommendations: Improve academic preparation in middle and high schools; provide financial incentives such as scholarships, loan forgiveness or tax credits; revise clinical curricula in medical school to emphasize ambulatory care; equalize compensation between primary care and medical specialties; and reform the malpractice insurance system.

INDIVIDUAL AND PUBLIC RESPONSIBILITIES

ALA/ATS POSITION: Education for health is the responsibility of many sectors of society including employers, schools, families, religious institutions, health providers and voluntary health agencies such as the American Lung Association, the American Thoracic Society, and others. Individual responsibility for health is crucial to an effective health care system. Through proper education individuals will become empowered, active, and aware of their responsibility for positive health behavior and maintenance of healthy life styles.

We believe strong, comprehensive health education programs are an integral part of preventive health care. These programs will encourage individuals to maintain healthy life styles and take responsibility for positive health behavior.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations and others to join the voluntary health community in providing comprehensive health education.

FINANCING AND COST CONTAINMENT

ALA/ATS POSITION: <u>Financing</u> – The financing of universal health care should avoid placing an inappropriate burden on any individual or particular sector within society and will require a degree of government support. Any premiums, deductibles, and co-payments for the basic level of services should be uniform. An individual's ability to pay shall not be a barrier to care.

ALA/ATS POSITION: <u>Cost Containment</u> – An employment-based health care system of universal coverage can be economically feasible only if there are cost containment features that address both aggregate budget expenditures and provider payments and are applied to all payers.

We believe the health care system should be financed through multiple sources, including the government, with no one sector or individual bearing an unfair or disproportionate share of the costs. We support a progressively financed system and believe that any premiums, deductibles, or co-payments required must be based on an individual's ability to pay.

Finally, we believe cost containment is essential for maintaining a "healthy" health care system and that a variety of tools can be used to rein in the spiraling costs of health care. We suggest tools such as outcomes research, the development of clinical practice guidelines, reform of the medical liability system, electronic submission of claims, a single uniform insurance form, and such other tools as necessary to address aggregate budget expenditures and provider payments.

ALA\ATS Task Force on Health Care Policy

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STATEMENT OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

THE BASIC BENEFIT PACKAGE

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents the nearly 5,000 (97%) board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

Our primary and overriding concern is that all citizens secure access to appropriate services and that plastic surgeons retain the right to provide those services with a minimal amount of regulatory or statutory restrictions.

ASPRS believes that all individuals in this country must have access to basic levels of health care services. These services must be available in a timely manner and by an appropriately trained physician. Gatekeeper systems should not be allowed to unduly obstruct access to specialized care. Access needs to exist regardless of socioeconomic or employment status.

Every American should have access to a universal set of benefits. Within the scope of plastic surgery, those benefits include all reconstructive procedures and exclude all cosmetic procedures as defined by ASPRS and AMA. Guidelines, practice parameters and indicators should be used when there are questions about specific procedures.

Plastic surgeons, as a result of providing burn and traumatic injury care, understand that access to trauma care needs special consideration. Access to an appropriate regional trauma center should not be denied under any circumstances for economic reasons.

The development of a basic set of health care benefits is possibly the most arduous and important task of health care reform. The benefit package must straddle the fine line between providing all necessary services and providing other desired services that we as a society are able and willing to pay for. The more extensive the package, the longer it will take for universal access to be achieved and the longer the present trends in health care will continue to burden our economy.

Plastic surgery presents a unique challenge to the development of this package. The wide variety of services that plastic surgeons provide fall into two major categories, reconstructive surgery and cosmetic surgery.

It is widely assumed that the specialty of plastic surgery is only involved in elective cosmetic or aesthetic surgery. This is not the case. Over 60% of a typical plastic surgeon's time is spent on reconstructive surgery. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Unfortunately, the important reconstructive procedures that plastic surgeons perform are often overlooked. Among the most publicized cases was that of a North Dakota boy whose arms were severed in a 1991 farm machinery accident. His arms were reattached by a plastic surgeon using microsurgical techniques. Another example is the couple in Nevada who were trapped in a blizzard for days, suffered frostbite and needed to have portions of their feet amputated. A plastic surgeon reconstructed the amputated portions of their feet.

These stories are well-known but by no means uncommon. Every day plastic surgeons treat patients in the most critical circumstances, repairing faces following gunshot wounds, reconstructing limbs after traffic accidents, reshaping skin after cancer ravages body tissue. With plastic surgery, a child with a cleft-lip and palate has hope of leading a normal life, free from respiratory and eating problems and free from the social stigma that many times accompanies those with a facial deformity. These types of plastic surgery services must be included in a basic benefit package. They provide vital quality health care services that affect all segments of this country's population.

Reconstruction, as exemplified here, allows these individuals to again become productive members of society. Reconstructive procedures heal both the physical and emotional scars left by deformities and trauma. A woman who has just gone through breast cancer and undergone a mastectomy feels whole again after breast reconstruction. The boy who lost his limbs or an individual who lost his fingers in an accident are all made whole again through plastic surgery. With reconstructive surgery, individuals have the ability to be self-sufficient and contribute to our economy. The benefit to society and the economy far outweigh the cost of the procedures.

The other portion of plastic surgery, cosmetic surgery, is performed to reshape normal structures of the body in order to improve the patient's appearance. Cos-

metic procedures include facelifts, nose reshaping, and other procedures done to improve appearance and enhance the quality of life for patients who choose to have this type of surgery.

Patients who choose to have cosmetic procedures come from all segments of American society. Cosmetic surgery is not a phenomenon of the idle rich. Cosmetic surgery is important to the patient. The fact that 65% of cosmetic surgery patients come from families with combined incomes below $50,000 shows how important these procedures are.

Despite the fact that cosmetic procedures are important to individual patients, it would be inappropriate for them to be included in a basic benefit package. Liposuction, tummy tucks and face lifts performed for aesthetic proposes should not be included in any benefit package.

For many procedures, it is not easy to determine where they should be placed. There are a number of plastic surgery procedures that should only be included when a particular diagnosis, or indication, is present.

For example, blepharoplasty, or the repair of a droopy eyelid, is essentially a cosmetic procedure. But there are cases in which a patient's eyelid may droop over the eye far enough to impair sight. In such circumstances, blepharoplasty should be reimbursed within the basic benefit package. In all other cases, blepharoplasty should not be covered. There are numerous other procedures similar to this.

The ASPRS has completed an extensive survey of its membership to determine which procedures should be included in a basic benefit package and if there are specific indicators of when a procedure should or should not be included. The day-to-day contact that plastic surgeons have with their patients gives them an understanding of those procedures that are important to health care consumers and the procedures that are appropriate to include in a benefit package.

The results of the survey indicate that a number of plastic surgery procedures should be included in the basic benefit package outright, some should be included only when a certain indicator or diagnosis is present, and others should be excluded altogether.

A rationally defined uniform benefit package, based upon the efficacy of a procedure for a certain diagnosis, has the potential of releasing physicians from the great discrepancies that exist in our current reimbursement system. Today, a service that is covered in one way by one carrier is covered differently, or not at all, by another carrier. Or, coverage for procedures sometimes arbitrarily cease without notice to the physician or patient.

Once the benefit package is determined, the appropriateness of inclusion of any procedure must be periodically evaluated through outcome and other studies. The development of clinical indicators, practice parameters and practice guidelines are under development by ASPRS and other specialty societies with assistance from many interested groups. ASPRS, and other groups, stand ready and willing to provide the professional judgements and decisions which will be needed to make safe and effective adjustments to the composition of the minimum benefits package.

We look forward to the day when patients and physicians know that for a given diagnosis, a certain procedure will be consistently covered around the nation. We look forward to the day when we can practice medicine and our patients will not be faced with uncertainty over whether a particular treatment is covered by their insurer.

If a standard benefit package is defined and implemented properly, it will also create incentives for technological advancements. It must be designed with incentives for physicians to seek more efficient and efficacious methods of practicing medicine.

A rational approach to determining a basic benefit package with input from patients and providers is essential to the success of health care reform. We look forward to working with the committee on this important component of health care reform.

STATEMENT OF THE M.D. ANDERSON CANCER CENTER, HOUSTON, TX; CITY OF HOPE NATIONAL MEDICAL CENTER, DUARTE, CA; DANA-FARBER CANCER INSTITUTE, BOSTON, MA; FOX CHASE CANCER CENTER, PHILADELPHIA, PA; FRED HUTCHINSON CANCER RESEARCH CENTER, SEATTLE, WA; ARTHUR G. JAMES CANCER HOSPITAL AND RESEARCH CENTER, COLUMBUS, OH; MEMORIAL SLOAN-KETTERING CANCER CENTER, NEW YORK NY; KENNETH NORRIS JR. CANCER HOSPITAL, LOS ANGELES, CA; AND ROSWELL PARK CANCER INSTITUTE BUFFALO, NY

ASSURING CANCER PATIENTS ACCESS TO APPROPRIATE CARE IN THE HEALTH SECURITY ACT

The National Cancer Program was enacted by Congress in 1971 to improve the prevention, diagnosis, and treatment of cancer. An important element of the program is the designation by the National Cancer Institute (NCI) of comprehensive and clinical cancer centers.

The NCI-designated cancer centers are the cornerstones for deepening the understanding of the causes and cures for cancer, for applying this knowledge to patients under treatment, and for disseminating this knowledge to community hospitals. The cancer centers have developed many of the major advances in cancer treatment.

The role of these national resources—and the continued success of the National Cancer Program—may be threatened by health care reform unless their special mission is taken into account:

- *The definition of an academic health center should include a cancer hospital that is excluded from the Medicare Prospective Payment System.* The President's proposed definition of an academic health center does not include cancer hospitals that are excluded from the Medicare Prospective Payment System.
- *Patients in managed care programs must be guaranteed access to the NCI-designated cancer centers.*

  Cancer patients must be permitted to choose treatment at an NCI-designated cancer center without extra financial charge.

  Otherwise the cancer centers could be available only to affluent patients.

  In addition, NCI-designated cancer centers should be automatically treated as designated specialty providers to which managed care plans must allow the referral of their enrollees.
- *The basic benefits package must cover treatment of cancer patients in qualified clinical trials that substitutes for standard, and possibly less effective, therapy.*

  The customary exclusion of "investigational" services must not extend to qualified clinical trials involving cancer patients, since the reasons for the exclusion do not apply to such trials.
- *Any rate-setting methodology must be designed to accommodate the atypical services and patients of these cancer centers.*

  These NCI-designated freestanding cancer centers treat a disproportionate number of severely ill patients and use particularly sophisticated techniques. Current law affords nine freestanding cancer centers special status under the Medicare reimbursement system because of their atypical services and patients. Comparable status for both in patient and outpatient services should be afforded the nine centers under any payment mechanisms adopted by states or health alliances.

THE CANCER CENTERS ARE NATIONAL RESOURCES

As part of the National Cancer Program, the NCI was directed to designate certain cancer centers to develop new treatments for cancer and introduce them into clinical practice.[1] These state-of-the-art therapies and research activities offer the greatest possibility for successful treatment of cancer patients. Moreover, research is the driving force that allows these cancer centers to develop new innovations that replace less effective cancer treatments and provide a positive impact on both the quality of life for cancer patients and the cost of treatment.

As the centers develop new methods for treating, preventing, and detecting cancer, they demonstrate their effectiveness through treatment of patients at the centers and disseminate information on these developments so that they can be incorporated into clinical practice throughout the country. Much of the progress made in understanding the biology of cancer and the treatment of this disease is directly attributable to the work done in these NCI-designated cancer centers.

These cancer centers have played pivotal roles in developing and advancing treatments for childhood leukemia which previously were often fatal and are now highly

[1] 42 U.S.C. §§285a through 285a–3.

curable; safely substituting lumpectomy for mastectomy in many breast cancer patients; developing techniques for the early detection of cancer; originating limb preservation techniques that minimize disability and disfigurement; developing bone marrow transplantation to cure previously untreatable cancers; and perfecting ambulatory cancer treatment for large numbers of patients. The work continues, as the cancer centers innovate in such areas as gene therapy and immunotherapy. The cancer centers' endeavors have contributed to the increasing number of survivable cancers and have enabled countless individuals to return to productive lives.

Health care reform must be undertaken in a manner that does not undermine the National Cancer Program nordeprive patients access to these cancer centers.

ASSURING ACCESS UNDER MANAGED COMPETITION

Many health care reform proposals, including the President's, are intended to foster the development of managed care. In any expansion of managed care, extreme care must be taken to assure that cancer patients are not denied the state-of-the-art treatment available primarily, and often only, at the NCI-designated cancer centers. These federally designated national resources must continue to be available to the general population and should not be limited to affluent patients who can afford high coinsurance payments or special insurance coverage.

Moreover, without a patient base with which to test promising new techniques, the essential translation of treatment advances from laboratory bench to the patient's bedside will not occur. Without patients, the cancer centers would be unable to carry out their mission under the National Cancer Program.

Therefore, any health care reform legislation must contain the following protections to assure access by cancer patients to the NCI-designated cancer centers—

- Any cancer patient enrolled in a managed care plan would be guaranteed the right to choose treatment at an NCI-designated cancer center. Managed care plans would be required to arrange for such treatment at the same cost to the patient as for in-network services.
- Managed care plans would be required to provide information on NCI-designated cancer centers to plan enrollees.

In addition, the President's proposal should be modified as follows—

- Health plans should be required to permit the referral of their patients to designated specialty providers and centers of excellence. This should be a state mandate—not a state option, as the President's plan would apparently provide.
- NCI-designated cancer centers should automatically be considered to be designated specialty providers or centers of excellence.
- Although the regional health alliances would be organized on a state basis, access to NCI-designated cancer centers should not be limited to in-state centers. Health plans should be required to permit the referral of their patients to an NCI-designated cancer center that can provide appropriate services regardless of location.

THE BASIC BENEFITS PACKAGE SHOULD COVER QUALIFIED CLINICAL TRIALS

A clinical trial on a new cancer therapy is initiated because of the belief, based on preliminary evidence, that the therapy is likely to be more effective than the conventional therapy otherwise available. The trial is intended to establish the superiority of the new therapy definitively. Patients in trials benefit since they receive treatment that may be substantially better than conventional treatment and that, in any event, is not likely to be less effective.

The NCI-designated cancer centers plan a major role in conducting clinical trials of new methods to prevent and treat cancer. Through such trials, the cancer centers develop the standard of treatment that are eventually used by physicians and institutions throughout the country. The system of NCI-designated cancer centers is a model structure for determining which treatments are effective.

Although clinical trials offer the possibility of superior treatment for cancer patients, insurers frequently deny coverage of the associated medical care, such as the hospital stay or physician visits, under policy or plan provisions excluding "investigational" or "experimental" treatment. By inappropriately invoking provisions designed to prevent payment for questionable or speculative treatments, insurers have adopted policies precluding reimbursement for state-of-the-art, advanced medical treatments that are frequently more effective, and ultimately most cost effective, than those the insurers would readily pay for.

The National Cancer Institute agrees that health insurance should cover clinical trials—

> "NCI does not consider the research exclusion justifiable. For patients with life-threatening diseases for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The NCI believes that clinical trials are standard therapy for cancer patients to whom a curative therapy cannot be offered. . . . For these reasons, we consider it appropriate for third-party carriers to reimburse patients for medical care costs of participating in scientifically valid clinical trials."[2]

The basic benefits package established in health care reform legislation must include coverage of the medical care associated with clinical trials provided to cancer patients if the trials have been approved by (1) NCI or an NCI-designates cancer center, cooperative group, or community clinical oncology program; (2) the Food and Drug Administration, in the form of an investigational new drug exemption (IND); (3) the Department of Veterans Affairs; or (4) a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants.

Coverage of cancer clinical trials should not increase aggregate health care costs. Treatment of cancer patients through clinical trials is ordinarily a substitute therapy that is not necessarily more expensive than conventional therapy.

The President's proposal would include the "routine costs" of approved clinical trials in the guaranteed national benefits package. The scope of routine costs is unclear at this time. While we would not expect administrative costs of the clinical trials to be covered, all patient care costs should be covered.

THE NINE FREESTANDING CANCER CENTERS SHOULD BE PROTECTED FROM INAPPROPRIATE RATE-SETTING PAYMENT METHODOLOGIES

Although most of the NCI-designated cancer centers are part of larger, diversified institutions, nine of them are renowned, freestanding facilities.[3] As such, they are particularly vulnerable to any health care financing measures that do not take their unique characteristics into account. For that reason, Congress determined that the Medicare diagnosis-related group (DRG) system was inappropriate for the nine centers.

By law, Medicare exempts the nine centers from the prospective payment system (PPS) for inpatient hospital services and instead pays them under a cost-reimbursement method.[4] Since PPS uses DRGs based on typical cases, Congress concluded that it would not be appropriate for the atypical services of, and patients treated by, the nine cancer centers.

In a June 1993 report, the Prospective Payment Assessment Commission (ProPAC) reconfirmed that the reasons for the statutory exemption continue to exist today.[5] The statutory exemption acknowledges the cancer centers' status as unique, state-of-the-art facilities with the most acutely ill cancer patient populations. Importantly, the exemption confirms that the existing cancer DRGs do not reflect the complexity of illnesses treated at the cancer centers, or the intensity of services provided.

If health care reform legislation allows or requires rate-setting, it should include special requirements governing the nine freestanding cancer centers comparable to the Medicare exemption. For example, under the President's proposal, the regional alliances would issue fee schedules for the fee-for-service health plans, and states could regulate payments under health plans to assist the health alliances in meeting the federally required premium targets.

As Congress recognized in exempting the nine freestanding centers from the Medicare prospective payment system, controls based on average cases or the experience of ordinary institutions, such as controls based on DRGs, would be completely inappropriate for these freestanding centers. Federal legislation should require a similar approach, with respect to both inpatient and outpatient services, for any rate-setting by states or regional alliances.

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[2] Raub, William F. "Remedies and Costs of Difficulties Hampering Clinical Research." January 1989. (Submitted to the Senate Committee on Appropriations in response to S. Rep. No. 100–399.)

[3] The nine are: M.D. Anderson Cancer Center, Houston; City of Hope National Medical Center, Duarte, California; Dana-Farber Cancer Institute, Boston, Massachusetts; Fox Chase Cancer Center, Philadelphia, Pennsylvania; Fred Hutchinson Cancer Research Center, Seattle, Washington; Arthur G. James Cancer Hospital and Research Institute, Columbus, Ohio; Memorial Sloan-Kettering Cancer Center, New York, New York; Kenneth Norris Jr. Cancer Hospital, Los Angeles, California; Roswell Park Cancer Institute, Buffalo, New York.

[4] 42 U.S.C. §1395ww(d)(1)(B)(v).

[5] Prospective Payment Assessment Commission. "Medicare and the American Health Care System Report to the Congress." June 1993. Pages 84–85.

An appropriate rate-setting methodology would be based on the historical costs (e.g., average-per-patient costs) of each freestanding cancer center, updated to reflect inflation and any significant changes in the center's patient case-mix or services provided. Any such methodology should be subject to revision based on changes at each center. Rates must be established in a manner such as this if the nine freestanding cancer centers are to remain viable.

ALTERNATIVE STATE SYSTEMS

Some proposed health care reform plans would allow states to substitute their own reform and cost control plans for the national program. If this is permitted, the federal legislation should require states to adopt the protections and benefits package requirements specified above. The National Cancer Program is an important federal initiative that should not be thwarted by state regulation that does not adequately accommodate the NCI-designated cancer centers.

SUMMARY

To ensure that the services of the NCI-designated cancer centers remain available to patients, and that these centers continue to provide complex, state-of-the-art treatment, it is essential that health care reform be structured to include the following elements:

- The definition of an academic health center should include cancer hospitals that are excluded from the Medicare Prospective Payment System.
- Patients in managed care plans suffering from cancer must be guaranteed access to the specialty services and treatment available at the NCI-designated cancer centers without the financial penalties assigned to out-of-network care.
- All managed care plans should be required to provide information on NCI-designated cancer centers, and how to access their services, to their enrollees.
- In the President's plan, NCI-designated cancer centers, including out-of-state centers, should be included as "designated specialty providers" to which health plans must allow the referral of their enrollees.
- Qualified clinical trials must be included in the basic benefits package.
- Rate-setting applicable to the nine freestanding cancer centers should be limited to an appropriate non-DRG rate-setting methodology for both inpatient and outpatient services.
- Any alternative state systems created under the health care reform legislation should be required to include comparable protections for the cancer centers and patients.

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

My name is Rob Schwartz. I am President of the National Association of Rehabilitation Facilities. We are submitting this statement for the record of your hearing on the guaranteed benefits package included in President Clinton's Health Security Act, S. 1757. NARF is a national organization representing over 900 members who provide medical, vocational, residential and employment services to over 4 million people annually.

We appreciate the seriousness with which this Committee is approaching the opportunity to reinvent, reestablish and recreate our health care system. We commend the chairman, the President, and other members of the Senate for tackling this difficult issue. The President's plan takes great steps toward providing health care to numerous people who do not have access to care, including persons with disabilities.

Over four million people receive rehabilitation services annually. Over 80% of these people return to their homes, work, schools or an active retirement. Conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in a number of places—freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgment. These settings, properly utilized, can provide a full continuum of rehabilitation care.

Our specific comments on the benefit package follow.

COMPREHENSIVE BENEFIT PACKAGE (section 1101 *et. seq*)

First we believe the benefits package must be established by law. The Clinton plan proposes a comprehensive benefit package which is to reflect the coverage most people receive today. It proposes coverage of both inpatient and outpatient rehabilitation services which NARF supports. We are pleased to see that the President has recognized rehabilitation. However, we have several comments on the package which we think will be an enhancement. Coverage of inpatient and outpatient rehabilitation services should provide a full continuum of care for people needing rehabilitation services and ideally they will be delivered as quickly and efficiently as possible to the major benefit and prompt recovery of a patient needing rehabilitation services. The recommendations we have for the comprehensive benefits package are offered with the intention of assuring that the full continuum of care is available to people.

A. Inpatient Hospital Rehabilitation Services (Section 1111)

This section covers inpatient and outpatient services provided by a hospital. The term "hospital" is defined by reference to the Medicare Act and includes "an institution . . . primarily engaged in providing . . . rehabilitation services for the rehabilitation of injured, disabled, or sick persons." The inpatient hospital services covered are those in section 1861(b)(1)–(3) of the Medicare Act.

Inpatient and outpatient services of rehabilitation hospitals and units must be covered in order to continue the coverage most people have now and enable the uninsured access to such care. The services of rehabilitation units in general hospitals should be covered by virtue of the larger institution being under the more general definition of a "hospital."

Recommendation: NARF supports coverage of inpatient rehabilitation hospitals and units and the services they provide in the hospital services benefit. Report language should include an explicit reference to coverage of rehabilitation hospitals and units and the services they provide under this benefit. A copy of such draft language is attached, as Attachment A.

B. Extended Care Services (Section 1119)

S. 1757 covers 100 days of extended care services. These would be provided in a skilled nursing or rehabilitation facility. Such coverage is available "as an alternative to inpatient treatment in a hospital after an illness or injury." A rehabilitation facility is defined as "an institution (or distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to an individual for rehabilitation from illness or injury."

This definition is virtually the same as that incorporated by reference from the Medicare Act to define a rehabilitation hospital. Thus, the Plan contains an ambiguity. Extended care services are to be provided as an alternative to hospitalization level rehabilitation by an institution that is defined to include rehabilitation hospitals and units.

Recommendation: For purposes of the extended care benefit, "rehabilitation facility" should be defined so that a continuum of care is available for rehabilitation patients, where possible through a single facility. The intensity of nursing and therapy services under the extended care benefit would be less intense than those needed by patients in a hospital level rehabilitation program. The Plan should be clarified to establish that a rehabilitation hospital or a rehabilitation unit in a general hospital can provide these extended care services as a rehabilitation facility" which will be at a less intense level than is the case for hospital level rehabilitation services. To do so the sentence above should be redrafted to read "such services are covered only as an alternative to inpatient treatment under section 1111." The draft report language in Attachment A also clarifies this point.

C. Outpatient Rehabilitation Services (Section 1123)

The Clinton Plan also covers outpatient rehabilitation services provided by entities other than a hospital. "Outpatient Rehabilitation Services" are defined to include physical therapy, occupational and speech therapy to restore functional capacity or to minimize limitations on physical and cognitive function as a result of illness or injury. The need for such services are to be evaluated after 60 days to determine if there is continued improvement in function.

Recommendations:

1. The list of services comprising the Outpatient Rehabilitation Services benefit should include psychology, social services and rehabilitation nursing services when provided by Comprehensive Outpatient Rehabilitation Facilities (CORFs) as defined under Section 1861 (cc) of the Social Security Act. The CORF benefit was added to

the Medicare Act in 1980 in recognition that rehabilitation is the collective and coordinated application of therapies and other services, rather than a series of individual services.

2. Cognitive therapy, audiology and hearing tests should also be added.

3. Congenital and developmental disabilities should be added to illness and injury as qualifying conditions for services.

4. The 60-day evaluation period should be used only as an evaluation period as is the current practice under Medicare with which the field is familiar, and not be interpreted as a limit.

D. Definition of the Benefit Package

The Clinton plan prescribes coverage of a benefits package, as does, S. 1770 and S. 491. Each of these includes coverage for rehabilitation services. However, several alternative plans, pending in the Congress would leave the determination of benefits to an administrative body.

E. Medical Necessity (Sections 1141 and 1154)

In order for any benefits package to work effectively and for the plan to work effectively, the plan requires that only medically necessary services would be made available.

Since the amount of money will be finite and the benefit structure fixed, the only variables available to cut costs are rates of payment to providers and the extent of care provided. Under these circumstances, there is a danger that specialty services such as rehabilitation will be restricted through determinations they are not medically necessary. This is an experience that several facilities have had under current managed care programs, both Medicare and non-Medicare. Accordingly, it is essential that the Plan contain clear and controlling standards for determinations of medical necessity.

Medical necessity is a function of the complexity of the medical, nursing and therapeutic needs of the patient. Services should not be compromised in terms of quantity or time. Medically necessary services are the most cost effective way to return people to their highest level of function and personal safety as soon as possible. The current Medicare hospital inpatient rehabilitation guidelines found in the Medicare Intermediary Manual at Section 3101.11 provide a good basis for determining the need for hospital rehabilitation services. They have been in use for 15 years, are well known and tested. The inpatient guidelines highlight the need for medical management and supervision, skilled rehabilitation nursing and other nursing, intensity of therapies (the hospital level is a minimum of three hours a day, five days a week of P.T., O.T. and other required therapies), plan of treatment and other factors. Additionally, there are outpatient rehabilitation guidelines for physical therapy, occupational therapy and speech language pathology services found in the Intermediary Manual at Sections 3904,3906 and 3905 respectively.

Recommendation: The Medicare coverage guidelines should be adopted for determinations of the need for rehabilitation by alliances and plans. In any event, the determination of medical necessity should be made by the attending physician.

While this hearing focuses on benefits we have several other areas of concern. They are:

- ADMINISTRATIVE STRUCTURE AND QUALITY OF CARE

While this hearing has focused on the issue of covered benefits, the other benefits factor that is of our concern is as follows: The benefits should be available to individuals in need of them.

The administrative structure proposed under the Health Security Act is a major systemic change in the delivery of health care services. Essential elements are the creation of a national health board, regional and corporate alliances, and accountable health plans. States will play a major role in creating alliances and certifying plans.

The plan encourages the use of health maintenance organizations and other types of managed care plans. Under managed care plans the receipt of services is determined by the decision maker, sometimes referred to as the gatekeeper. Given the constraints on financing, there may be a natural tendency to refer to the least expensive level of care, which may not assure that the most effective outcomes for persons needing services. We would hope, given our negative experiences with such organizations, that reinvention would eliminate the problems of the past.

As reported by our members, our experience with current managed care plans has been problematic. Additionally, several studies show that managed care plans do not deliver all medically necessary services. Let me give you some examples.

A man riding his bicycle in the Arlington, Virginia area fell and suffered a serious spinal cord injury. He is being rehabilitated at a local rehabilitation hospital and is insured by a local HMO. His physician predicts he will need at least three months of inpatient rehabilitation, but his insurance plan covers only two months. Ironically, this results in his scheduled released on Valentine's Day.

In California some years ago, two men suffered spinal cord injuries. One was rehabilitated and returned to his family, job and previous life. His colleague, disappeared from rehabilitation one day. The rehabilitated man asked about the second man. He found that he had been sent to a custodial nursing home where all of the major gains while in rehabilitation. Now he was totally dependent. His HMO would only cover 60 days of care. He received no additional therapies except for being turned in bed only once a day.

Some HMOs do not refer to comprehensive or acute rehabilitation program as a matter of practice even though the patient meets admission criteria. NARF recently learned that a large risk based HMO will not refer stroke patients to acute rehabilitation, instead they are sending them to a nursing facility without the benefit of intensive rehabilitation therapy. This rule of thumb may be inappropriate for all stroke patients. As in the studies conducted on the cost benefits of stroke rehabilitation have shown considerable savings. A 1981 study showed that for each stroke patient who, through rehabilitation, was able to live at home, this expense versus a long term residential institutional setting saved $13,248 per year in 1981 dollars or $20,447.61 in 1992 dollars. Given that the average stroke patient lives over five years this is a savings of $102,238.12 in 1992 dollars.

A study in California also noted some of the serious problems in the failure to refer to rehabilitation services and the quality issues this presents (Medicare Risk Based Contract HMOs of California: A Study of Marketing Quality and Due Process Rights, Medicare Advocacy Project, Los Angeles, California 90057, January 1993). Also a recent study by Mathimatica, Inc. raised some serious questions regarding quality of care and referral of appropriate patients to rehabilitation hospitals and units. For example, medicare patients were being referred to skilled nursing homes. The outcomes were not as positive as those in rehabilitation programs.

A recent managed care survey of NARF members revealed the following: 51 of 57 respondents had contracts for non-Medicare enrolles, 27% said that the HMO in their area does not refer these patients to rehabilitation hospitals and units. For Medicare enrollees, 31 of 57 facilities contract with HMOs, 50 percent reported that the HMO does not refer Medicare enrollees in need of rehabilitation to rehabilitation hospitals and units and 57 percent report that the HMO takes the position that rehabilitation is not medically necessary. Therefore, a mechanism must be in place to assure the referral for, and the delivery of, appropriate covered rehabilitation services.

To assure appropriate, high quality services are delivered to persons requiring rehabilitation services, particularly persons with disabilities, national standards must be established. Such standards must be met by states before health plans are approved by a health board or similar entity, and prior to any state certifying a health plan or designating an alliance. These standards must be consistent from state to state and alliance to alliance. The standards that we propose approach this from three perspectives. See Attachment B.

The standards should ensure that the decision maker, or gatekeeper would have criteria by which to determine immediately if an individual needs rehabilitation services. An individual would receive an immediate rehabilitation evaluation if he came to his gatekeeper with one of the 15 conditions normally requiring rehabilitation services. Rehabilitation should be a requirement included in all medical college and allied health curricula. Persons with disabilities should have an opportunity to choose a specialist in rehabilitation as their primary care provider or primary physician from a panel of specialists offered by the plan.

The standards should include safeguards during the treatment period. These would involve stated times for appointments, follow-up appointments, transportation, etc. Finally, the standards would measure the referral of services retrospectively through chart reviews and other quality assurance mechanisms that would be included in the consumer report card.

- **COVERAGE MANDATE AND DEFINITION OF AN EMPLOYEE (Sections 1001, 1901)**

Recommendations:

1. The Plan should not include in the definition of "employee" persons who are receiving Supplemental Security Income or Social Security Disability Income.

2. The two-year waiting period for Medicare eligibility by virtue of disability should be eliminated. Persons found to be disabled under Social Security should receive immediate Medicare coverage, retroactive to the date of disability.

3. Fringe benefit allowances in wage rate on Javits-Wagner-O'Day contracts should be increased as necessary to include the cost of health insurance as mandated by the Health Security Act.

4. Rehabilitation facilities and their employees should be eligible for all subsidies in the Plan for payment of health insurance premiums.

- ADMINISTRATIVE STRUCTURE (Title I, Subtitles C, D, E and F, Part 1)

A. National Health Board

Recommendations:

1. The Board should set the standards discussed above.

2. The membership of the Board should be expanded and include a provider of rehabilitation services, a consumer of rehabilitation services, and a person with disabilities.

B. State Responsibilities (Section 1200 et. seq)

Recommendations:

1. Rehabilitation providers should be eligible to become centers of excellence in Section 1203(e)(2).

2. Rehabilitation providers should participate with states on all advisory and planning committees.

C. Health Alliances (Section 1300 et. seq.)

Recommendations:

1. The patient classification system based on the function related groups (FRGs) system needs to be finalized so that plans, alliances, and providers can negotiate rates and schedules knowing who their patients are and their projected resource use.

2. Plans should also comply with the standards recommended.

3. The Provider Advisory Board should include rehabilitation providers, not just professionals.

4. **NARF supports** the annual open enrollment period to allow individuals to switch plans if they find their current plan unsuitable. People needing rehabilitation services and persons with disabilities need this flexibility, especially if their plan is not responsive to their needs.

5. Rehabilitation providers should have an opportunity to work with each alliance in developing the outcomes information to be requested. NARF is developing a patient classification system (FRGs) that can predict length of stay based on the patient's functional status at admission. It is being refined to examine functional change from admission to discharge.

6. **NARF supports** the role of the ombudsman, but recommends that it be strengthened to assure prompt resolution of enrolles' concerns. Again, our previous experience with managed care companies and their focus on saving funds has been at the expense of enrollees.

D. Health Plans (Section 1400 et. seq.)

Recommendations:

1. To assure referral and delivery of necessary rehabilitation services, plans should meet the standards recommended above.

2. There should be an adequate number and variety of rehabilitation providers allowed to contract with each plan to assure that a full continuum of care is available to plan enrollees.

3. **NARF supports** the nondiscrimination provisions which prohibit preexisting conditions clauses and practices that have the effect of attracting or limiting enrollees on the basis of personal characteristics, including health status and the anticipated need for health care, among others.

- RISK ADJUSTMENT (Section 1541)

Recommendations:

1. Add functional ability and assessment to the list of factors used for risk adjustment in order to avoid an impediment to enrollment of persons with disabilities by health plans. Disincentives to enrollment should be removed. An appropriate risk adjustment formula is one factor in removing such disincentives.

2. Rehabilitation providers and persons with disabilities should be represented on the Advisory Committee for the Risk Adjustment System.

- PLAN PAYMENTS AND BUDGETS (Section 6201 et. seq.)

Recommendation: The Plan should be modified to include a requirement that payments to providers for services covered under the Plan conform to the standard now governing state plans under the Medicaid program (the Boren Amendment). This requires that such rates "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, regulations and quality and safety standards."

- MEDICARE COST SAVINGS (Sections 4101 and 4103)

Recommendation: NARF proposes rebasing of TEFRA limits for rehabilitation hospitals and units for a two-year period and adoption of a Medicare prospective payment system for rehabilitation. Furthermore, the types of patients coming to rehabilitation hospitals and units has changed over the last 13 years. To recognize these changes, the current criteria used to define a rehabilitation hospital of unit for exclusion from the PPS should be expanded to add pain, oncology, cardiology and pulmonary.

- QUALITY MANAGEMENT PROGRAM (Section 5001)

Recommendations:

1. Rehabilitation's focus is on improved motor and cognitive function which are measurable outcomes. The outcomes information requested should include information on improvement in physical and cognitive functions as well as including vocational and living status.
2. Rehabilitation providers should be members of and work with the National Quality Management Council and National Quality Consortium, each state, alliance and plan in developing the outcomes.
3. Persons with disabilities should be represented on the national council and any other committees charged with developing the quality management program.
4. Rehabilitation providers should be included in the development of practice guidelines and utilization review protocols at the national, alliance and plan levels.
5. Rehabilitation providers should be included in the design and conduct of outcomes research which should focus on the resulting quality of life of patients as well as more narrow indicators of functional ability.

- LONG TERM CARE (Title II, Subtitle B)

Recommendations: NARF supports this new commitment to long term services with an emphasis on home and community based services. NARF also supports the use of multiple eligibility criteria provision of personal assistance services, emphasis on consumer involvement, and the basic philosophy that long term services must be part of a health care reform program.

NARF also recommends:

1. Eligibility should be expanded to cover three of five ADLs or four of seven IADLs (mobility, communication, managing money, taking medications, shopping, etc.).
2. **NARF supports** recognition of cognition as an eligibility factor.
3. The personal assistance services included under the program look more like personal care services. While a good first step, **NARF recommends** that states be required to offer a full range of personal assistance services.
4. NARF is concerned that there be no incentives between the alliance based health plan and the LTC plan to limit the rehabilitation services people are receiving under the alliance plan, and move them prematurely to a LTC plan. **NARF recommends** that, before services are terminated under the alliance plan, there be a separate evaluation to determine if continued functional improvement is possible and that the plan is not terminating them prematurely or for its financial advantage.
5. Consumers must continue to have a role in the initial development of plans and services that are delivered at the national, state and individual plan level.
6. There should be a cap placed on out-of-pocket coinsurance payments.
7. Psychiatric services required over time which are beyond those covered by the basic benefits package should be addressed.
8. Issues regarding state medical practice and nurse practice acts in relation to health-related tasks performed by personal assistance providers such as medication administration and catheterization should be resolved.

- TAX INCENTIVES FOR PERSONS WITH DISABILITIES WHO WORK (Section 2501, 7901)

Recommendation: NARF supports this proposal.

ATTACHMENT A—REPORT LANGUAGE TO ACCOMPANY THE HEALTH SECURITY ACT

COVERAGE OF INPATIENT REHABILITATION SERVICES

With regard to inpatient rehabilitation services, section 111 of the bill provides for coverage of hospital rehabilitation. Hospitals providing rehabilitation services, including both rehabilitation hospitals and rehabilitation units in general hospitals, are defined by reference to the definition of "hospital" in section 1861(e) of the Social Security Act. The bill includes as inpatient hospital services those under section 1861(b) (1)–(3) which covers all services currently provided by rehabilitation hospitals and units.

Section 1119 of the bill provides for coverage of extended care (EC) services by a rehabilitation facility. The term "Rehabilitation Facility" is defined in 1119(c)(1) to be "an institution (or a distinct part of an institution) which is established and operated for the purpose of providing diagnostic, therapeutic, and rehabilitation services to individuals for rehabilitation from illness or injury." Section 1119(b)(1) of the bill as introduced provided that EC services are covered only as alternative to inpatient treatment in a hospital.

It is the Committee's intent that the bill cover both hospital level rehabilitation services and rehabilitation services in extended care for patients who do not require the level of treatment and intensity of medical supervision of hospital level rehabilitation services provided in rehabilitation hospitals and units. The Committee also feels that providers of inpatient rehabilitation services should be encouraged, or at least permitted, to provide services under both benefits to facilitate continuity of service to patients. To this end the language of 1119(b)(1) has been modified to provide that the EC benefit is covered only as an alternative to treatment under the hospital services benefit. This change is intended to permit a rehabilitation hospital or unit to provide both levels of service.

Unlike the Medicare Act, which bases payment on the type of facility providing service, the Health Security Act does not prescribe methods of determining payments to providers. Methods and rates of payment are left to negotiation between health plans and providers. With regard to inpatient rehabilitation services, the Committee expects that health plans will prescribe standards to differentiate between hospital and extended care rehabilitation services and to vary payment for services accordingly. Currently the Medicare program draws such a distinction in its guidelines for coverage of inpatient hospital services, which specify the intensity of medical supervision, therapy services and nursing to be provided in hospitals. Such guidelines also require preadmission screening, coordinated care under the supervision of a mulidisciplinary team and improvement of function by the patient to continue treatment. The Committee expects health plans to adopt the same or similar guidelines to distinguish rehabilitation services covered by the hospital services benefit from those covered under the extended care benefit.

OUTPATIENT REHABILITATION THERAPY

SECT. 1123. OUTPATIENT REHABILITATION SERVICES

A. COVERAGE. The outpatient rehabilitation services described in this section are:

1. outpatient occupational therapy;
2. outpatient physical therapy;
3. outpatient respiratory therapy; and
4. outpatient speech-language pathology services and audiology services.

B. LIMITATIONS. Coverage for outpatient rehabilitation services is subject to the following limitations:

1. RESTORATION OF CAPACITY OR MINIMIZATION OF LIMITATIONS. Such services include only items or services used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.

2. MAINTENANCE OR PREVENTION PROGRAM. Services described in paragraph (1) include the following outpatient rehabilitation services designed to maintain functioning or prevent or minimize further deterioration:

(a) the initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(b) the designing by the qualified rehabilitation health professional of a maintenance or prevention program which is appropriate to the capacity and tolerance of the patient and the treatment objectives;

(c) the instruction of the patient, family members, or support personnel in carrying out the program; and

(d) reevaluations.

3. REEVALUATION.

(a) At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (2), the need for continued services shall be reevaluated by the person who is primarily responsible for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

(b) Periodically, outpatient rehabilitation services described in paragraph (2) shall be reevaluated by a qualified rehabilitation health professional.

EXPLANATION OF CHANGES

1. ILLNESS OR INJURY.

The bill limits coverage of outpatient rehabilitation therapies to those therapies used to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of illness or injury." This policy is tantamount to perpetuating a pre-existing condition clause for persons with congenital conditions. It results in arbitrary distinctions between two infants with the same pattern of disability and the same need for identical services. For example, there is no difference between the need for outpatient rehabilitation therapy services by a child born with cerebral palsy and a child who one hour after birth develops an infection in the brain (meningitis) and then develops cerebral palsy.

Solution: Insert **"illness, injury, disorder or other health condition"** in lieu of "illness or injury." The phrase in bold is consistent with language used elsewhere in the Health Security Act (at page 846 of S. 1757) with respect to development of practice guidelines.

This solution is consistent with policies included in many private insurance policies (e.g., Blue-Cross/Blue Shield; Government Employees Hospital Association). According to discussions between the March of Dimes and the Health Insurance Association of America, even those policies that include "illness or injury" language in fact cover therapies required to address a congenital condition. However, negotiations between the insurer, family and health professionals often are required.

2. RESPIRATORY THERAPY.

It is our understanding that respiratory therapy is intended to be included under the Health Security Act. This simply clarifies this understanding.

3. SPEECH PATHOLOGY.

The bill limits coverage to "outpatient speech pathology services for the purpose of attaining or restoring speech." This description is not reflective of the breadth of need. "Speech-language pathology" is the accepted term rather than "speech pathology" because the speech-language pathologist assesses and treats individuals who have speech, language, and related disorders.

Examples of language disorders include aphasia due to a stroke or head injury. The ability to speak may be intact but the ability to use the appropriate vocabulary or even find the appropriate word may be impaired. Additionally, speech-language pathologists can provide swallowing assessment and rehabilitation services. For example, an infant with cerebral palsy may require speech-language pathology services to learn who to swallow. Without the therapy, the child might choke on food or not be able to eat at all. Further, audiology services are important for individuals with hearing impairments. Audiologists provide diagnostic and aural rehabilitation services to individuals with hearing loss.

Solution: Insert **"Speech-language pathology services and audiology services"** in lieu of "speech pathology services for the purpose of attaining or restoring speech."

This solution is consistent with policy under Medicare and most private insurance policies. Although audiology is not mentioned in the Medicare statute, it is a covered service as defined in Section 2070.3 of the Medicare Carriers Manual.

4. MAINTENANCE OR PREVENTION PROGRAM.

The bill specifies that therapies are provided to minimize limitations on physical and cognitive functions." While payment for services designed to maintain functioning or prevent or minimize deterioration are recognized under existing private and

public policy, questions have been raised whether the language of the bill is sufficiently clear to reflect this policy.

Under Medicare policy, "maintenance programs" are covered. The premise of the policy under Medicare is that repetitive services required to maintain functioning or prevent or minimize deterioration do not necessarily involve complex and sophisticated therapy procedures, and consequently provision by a qualified rehabilitation health professional are not always required for safety and effectiveness. However, Medicare also recognizes that the specialized knowledge and judgment of a qualified rehabilitation health professional may be required to establish, monitor, and oversee a maintenance program.

The proposal clarifies the language in the Health Security Act to ensure that outpatient rehabilitation services includes maintenance and prevention programs, whenever medically necessary or appropriate.

The language is based on language in Medicare policies. The language is also consistent with statements by the Administration that the bill language is intended to include training individuals, their families, and others to continue working to maintain functioning and prevent deterioration.

The proposal includes the term "rehabilitation health professional" in lieu of "therapist." The recommended terminology is consistent with the definition of "health professional" set out in §1582 of the Health Security Act.

5. REEVALUATION.

Under the bill, additional periods of services are covered only if such person determines that "function is improving." This language is ambiguous in light of the scope of services provided under Sect. 1123(b)(1); i.e., restore functional capacity or minimize limitations on physical and cognitive functions.

The proposal strikes "Additional period of services are covered only if such person determines that functioning is improving" and inserts in lieu thereof "Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied."

This clarification is consistent with the clarification made by the Administration with respect to home health care (See §1118 of the Health Security Act as compared to the September 7, "Working Group draft" at page 24).

The reevaluation section also reflects the different requirements for reevaluation for a "maintenance or prevention program.

OUTPATIENT REHABILITATION COVERAGE REPORT LANGUAGE FOR SEC. 1223 OUTPATIENT REHABILITATION SERVICES, (A) COVERAGE

Coverage of outpatient rehabilitation services includes those services provided by a comprehensive outpatient rehabilitation facility. The comprehensive outpatient rehabilitation facility (CORF) benefit was added to the Medicare Act in 1980 (Section 1861 (cc)) in recognition that rehabilitation is the coordinated application of therapies and other services, rather than a series of individual services. A CORF is primarily engaged in providing (by or under the supervision of a physician) diagnostic, therapeutic and restorative rehabilitation services. Covered CORF services include physicians' services; physical therapy, occupational therapy, speech-language-pathology, and respiratory therapy; prosthetic and orthotic devices, including testing, fitting, or training in the use of these devices; social and psychological services; nursing care; drugs and biologicals; supplies and durable medical equipment; and other items and services that are medically necessary for the rehabilitation of the individual.

ATTACHMENT B—PROPOSED PLAN STANDARDS FOR HEALTH CARE REFORM UNDER THE HEALTH SECURITY ACT

Congress, in its directions to the National Health Board, the states, alliances and plans must establish standards that states must meet and that they will require the alliances and plans to meet before the Board approves a state's plan. These standards presume that rehabilitation services are covered in the national benefits package as proposed in the President's plan.

1. Each plan should have direction and incentives to deliver medically necessary services. One way to do so is require that when an enrollee sees a primary care provider, the primary care provider must perform a rehabilitation evaluation within 72 hours for patients who fall into the diagnoses most commonly treated by rehabilitation or have a congenital disability. These diagnoses include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neuro disorders, burns, cancer, cardiac and pulmonary diseases and pain.

A second way to assure delivery of services is to require education for primary care providers on rehabilitation. It should be a requirement of their curriculum.

2. Plans must deliver medically necessary rehabilitation services. The standard for medically necessary care must include factors relating to the medical condition of the patient, needed therapy and ancillary services, intensity of medical supervision required, intensity of nursing, improvement in functional capacity, prevention of deterioration and prevention of secondary complications and disabilities. The Medicare inpatient rehabilitation hospital guidelines, Section 3101.11 of the Intermediary Manual, have been used for over 15 year to determine the medical necessity of hospital level rehabilitation services.

3. Plans must demonstrate that any financial rewards must be for the appropriate referral for diagnostic and specialty, such as rehabilitation services.

4. Each plan must demonstrate where services will be available so that a full continuum of rehabilitation services is available to enrollees.

5. The total quality management program must include an audit to see if patients with typical rehabilitation diagnoses are referred for rehabilitation services.

6. Plans must allow all enrollees who have disabilities or chronic conditions to choose a physiatrist or other qualified rehabilitation physician as their primary care provider, care manager or gatekeeper.

7. Plans must be required to develop (a) maximum waiting periods for appointments, both initial and followup, and get referrals to specialists; and (b) standards for maximum travel distances.

8. Plans must assure that the grievance and appeals procedures be available to both enrollees and providers; that they include short timelines for review of a service denial; and they are clearly communicated to all parties. Plans must have procedures for obtaining an independent second opinion promptly when covered benefits are denied for any reason. Qualified rehabilitation professionals should review any denial of benefits.

9. In specific cases, a patient should be allowed to go out of plan for specialized covered services.

10. If the plan uses case managers, the case managers working with enrollees who need rehabilitation services must be knowledgeable, trained and educated in rehabilitation.

11. Plans must involve rehabilitation providers in the development of utilization review procedures and practice guidelines.

Statement of the National Wholesale Druggist Association

INTRODUCTION

With health care reform a national concern, the government is facing the difficult challenge of expanding access to high quality health care services at an affordable price. As a vital link in the delivery of pharmaceutical care to America's consumers, the wholesale drug distribution industry stands ready to help the country meet those goals.

The National Wholesale Druggists' Association (NWDA) is the national trade association for full-line, full-service drug wholesalers. Our members operate 250 distribution centers across the country that handle more than 98 percent of the wholesale sales of pharmaceutical products nationwide.

Today, the wholesale drug distribution channel is unquestionably the most cost-effective means for pharmaceutical manufacturers to deliver product to market.

Drug wholesalers distribute almost three-fourths of prescription drugs in the United States, up from 57 percent in 1980. This increasing market share reflects the efficiencies and value-added services that wholesale drug distributors offer both their suppliers and pharmacy customers.

Operating in a highly competitive marketplace, wholesale distributors have passed the savings from lower operating costs on to their customers. These customers constitute the entire range of health care facilities: independent retail pharmacies; chain drug stores and warehouses; hospital pharmacies; supermarkets with pharmacies; clinics; HMO and managed health care pharmacies; nursing homes; physicians; mail order; mass merchandisers' pharmacies; prisons; and state and federal institutions.

NEED FOR A PHARMACEUTICAL BENEFIT

Because our members are committed to providing efficient and safe delivery of pharmaceuticals to the health care marketplace, NWDA is equally committed to the belief that the cost-effective chain of pharmaceutical benefits be extended beyond

the delivery truck. The inclusion of a prescription drug benefit is a long overdue recognition of the contribution prescription medication makes in cost effectively treating illnesses. This benefit, as well as the Medicare drug prescription benefit, must remain as one of the cornerstones of any efficient health care system.

Appropriate pharmaceutical therapy and care not only improve the quality of life for millions of Americans, but also help lower overall health care expenditures by reducing the need for more costly medical interventions—such as surgeries, hospitalizations, long-term institutional care and repeated visits to a physician—and by improving premature morbidity and mortality rates, especially among infants. To give just a few examples, a study by California's Medi-Cal system found that the use of a prescription medication to avert coronary events by reducing blood fats produced annual savings of more than $5 million. In another example, a Department of Veterans' Affairs study found that for many patients medication was as effective as coronary artery bypass surgery while costing $300 a year compared to $41,000 for surgery. Finally, former Health and Human Services Secretary Louis Sullivan has noted that new drugs to treat respiratory distress have cut infant deaths 8 percent a year since 1989. These are just a few of the many examples that could be cited to show the positive impact pharmaceuticals have.

GUARANTEEING PHARMACEUTICAL CARE

Coverage of pharmaceuticals is only the first step in ensuring that both the patient and the health care system receive the greatest benefit from pharmaceutical therapy. A complete pharmaceutical package also should include coverage for pharmaceutical care and services. The pharmacist, working in conjunction with the rest of the health care team, can have a great impact in managing a patient's course of drug therapy to ensure that a patient complies with treatment instructions. The pharmacist also can review that the proper medication is prescribed in the proper dosage for a given patient and that treatment is compatible with other medications a patient may be taking. By working to achieve optimum outcomes, these measures address both the quality of health care treatment and cost efficiency.

Any pharmaceutical benefit should recognize that patients may need different levels of pharmaceutical care. To maximize therapeutic outcomes—thus providing the most effective and economically sound treatment—a pharmacist must manage the drug-use process by addressing a patient's individual needs. Thus, any pharmaceutical benefit should encourage and support access to a wide range of services—including drug utilization review and patient outcome analysis—and provide the pharmacist the flexibility to tailor the services to the individual patient.

This type of coordinated care addresses both the quality of health care treatment and cost efficiency. If pharmaceutical services are not covered as part of the prescription drug benefit, too many Americans will be deprived of a pharmacists' important contribution to effective and cost-efficient treatment. Total pharmaceutical care should be included in a prescription drug benefit provision.

MEDICARE DRUG BENEFIT

Another essential element that should be included in any health care reform legislation is coverage for the segment of the population that is most in need of prescription drug therapy and too often least able to afford it—our senior citizens.

Numerous studies have found that Medicare beneficiaries are twice as likely as non-Medicare beneficiaries to lack prescription drug coverage from any source. Eighty percent of Americans 65 years of age and older are afflicted with at least one chronic condition, such as heart disease, hypertension, arthritis or diabetes, all of which require prescription drugs on an ongoing basis. The incidence of these chronic conditions is highest among those 80 and older, among whom coverage for prescription drugs is lowest.

NWDA commends the administration for including a Medicare outpatient pharmaceutical benefit in its proposal. However, since the introduction of this proposal, there has been much discussion about the cost of the Medicare drug benefit. Unfortunately, there has been too little recognition of the savings that would result from its implementation.

For example, a study that reviewed the cost experience of a New Jersey program that provides prescription drug coverage to low and moderate income seniors 65 and older determined that the benefit cost was offset by hospitalization reductions. Another study was conducted of nursing home experience in New Hampshire, before, during and after implementation of a three drug prescription cap. It was discovered that nursing home admissions and costs increased when the cap was in place and decreased after it was removed.

A recent study conducted by Lewin-VHI (*Savings From A Medicare Pharmaceutical Benefit,* February 18, 1994) examined the Medicare drug benefit proposal in the Health Security Act and determined that the "use of cost-effective pharmaceuticals, more appropriate use of pharmaceutical products and diffusion of advanced pharmacy services could save the Medicare program an estimated $29.2 billion between 1996 and 2000." "Savings identified could offset roughly half (49%) of the direct costs of the outpatient prescription drug benefit between 1996 and 2000; these savings are contingent on diffusion of an advanced pharmacy benefit among the entire Medicare population." Finally, the study admits that the findings understate "the true savings because cost savings from the use of many pharmaceutical products have not been quantified in the literature."

Clearly, a Medicare drug benefit would be a cost-saver in the long-run and it should be included in any health benefit reform legislation enacted by Congress.

SUMMARY

The goal of health care reform should be to promote efficient, cost-effective and beneficial treatment. With that objective in mind, a full-fledged out-of-hospital pharmaceutical benefit, pharmaceutical care reimbursement and a Medicare drug benefit should be required elements of a minimum benefits package in a successful health care reform plan.

An efficient and cost-effective system for delivering pharmaceutical products and care—from the discovery of the drug in the research center through the warehouse until the patient is declared well—is in place today. At just 7 percent of the nation's health care expenditures, pharmaceuticals and related health care products—when utilized in the proper manner and under the appropriate supervision—are among the most cost-effective methods of health care available. Under the current health care system, however, pharmaceutical care is underutilized to the detriment of both the patient and the system.

Wholesale drug distributors offer dramatic proof that it is possible to reduce costs while increasing quality service. Wholesale drug distributors have made and will continue to make a significant contribution to reducing the bottom line on health care expenditures. We welcome the opportunity to work with this committee, Congress and the administration as we all strive to ensure that the American public receives both the best and the most cost-effective health care.

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